American Century Life Insurance Company of Texas
1333 W. McDermott Dr., Suite 150
Allen, TX 75013
Phone (855) 966-1111
Fax (855) 855-0181

Request to Reinstate Policy

(for forms L-222, L-222D, Term 5R)

Name of Policy Owner: _____ Policy Number: _____

Name of Insured: _____ Issue Date: _____

Please reinstate the above named policy effective at the date of this request.

Enclosed is a payment for $ _____ to cover the amount of premium due on the policy.

		Yes	No
1.	Does the Insured have a physical or mental condition that requires ongoing medication or medical treatment (excluding controlled high blood pressure, high cholesterol, or diabetes)? If "Yes," please provide additional details	☐	☐
2.	Is the Insured currently awaiting for a medical diagnosis or results from a medical test that have not been completed, or been advised to have surgery that has not been completed?	☐	☐
3.	Has the Insured ever been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for HIV (Human Immuno-Deficiency Virus) or any other immunological disorder?	☐	☐
4.	Has the Insured ever been diagnosed with or treated for or suffered a heart attack, stroke, angina, congestive heart failure, coronary artery disease or any other heart of circulatory disorder?	☐	☐
5.	Has the Insured ever been diagnosed with or treated for cancer, malignant melanoma, leukemia, insulin dependent diabetes, respiratory disorder, any chronic lung disease or disease of the liver of kidney?	☐	☐
6.	Has the Insured ever been diagnosed with or treated for Alzheimer's disease, dementia, alcoholism, drug abuse, Crohn's disease, disease of the central nervous system, mental disorder or been declined for life insurance in the past six (6) months?	☐	☐
7.	In the past year, has the Insured been hospitalized, resided in a hospice nursing home or other convalescent care facility?	☐	☐

Current height: _____ Current weight: _____

List any medication you are currently taking, if any:

Medication Name & Dosage	Diagnosis/Condition

Medication Name & Dosage	Diagnosis/Condition

_____ _____

Policy Owner Signature **Insured Signature**

_____ _____

Date **Agent Signature**