



American Century Life Insurance Company of Texas

1333 W. McDermott Dr. #200

Allen, TX 75013

Phone (855) 966-1111

Fax (855) 855-0181

Request to Reinstate Policy

(for form L-222J)

Name of Policy Owner: _____

Name of Insured: _____

Policy number: _____ 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

- 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
- 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?
- Has the Insured ever been diagnosed with or treated for AIDS, ARC or tested positive for HIV or any other immunological disorder?
- Is the Insured currently or in the past year been hospitalized, resided in a hospice nursing home or other convalescent care facility?
- 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?
- 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?
- Has the Insured ever been diagnosed with or treated for Alzheimer's disease, dementia, alcoholism, drug abuse, Crohn's, disease of the central nervous system, mental disorder or been declined for life insurance in the past six (6) months?
- Has the Insured ever smoked in the past 12 months?
- Is the Insured bedridden, confined to a wheelchair, or during the past year have had any type of amputation caused by disease?
- Within the past year, has the Insured:
 - had a heart attack, stroke or internal cancer?
 - been treated for complications of diabetes, diabetic coma or insulin shock?
 - been diagnosed with or treated for kidney failure, Alzheimer's disease, or had dialysis, or Cirrhosis of the liver?
 - used oxygen equipment at home to assist in breathing?

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: _____