PACIFIC LIFE

PACIFIC LIFE INSURANCE COMPANY

Lynchburg Operations
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P.O. Box 2873, Omaha, NE 68103
(844) 276-0193 • Fax (949) 219-8811 • www.PacificLife.com

REINSTATEMENT APPLICATION FOR INDIVIDUAL LIFE INSURANCE

Proposed Insured

1. Name: First	MI	Last			2. Policy Number
3. Residence Address: Street	City	State	Zip Code	4. SSN/TIN	5. Phone Number
6. Employer's Name					7. Occupation

General Information

	Yes	No
1. In the past five years, have you flown, or do you intend within the next two years to fly, as a pilot, student pilot, or crewmember other than for a scheduled commercial airline? (If Yes, complete the Aviation Supplement.)	☐	☐
2. In the past two years, have you engaged in, or do you intend within the next two years to engage in, hang gliding, ultra-light flying, hot-air ballooning, mountain, rock or ice climbing, motor vehicle or boat racing, or scuba or sky diving? (If Yes, complete appropriate activities supplement.)	☐	☐
3. In the next two years, do you intend to travel or reside outside of the United States for more than four consecutive weeks other than for vacation? (If Yes, complete the Foreign Residence/Travel Supplement.)	☐	☐
4. Have you ever had life insurance declined, rated, modified, cancelled or not renewed? (If Yes, provide details in the Remarks section.)	☐	☐
5. In the last five years, have you been convicted of a felony or misdemeanor or do you have such charge currently pending against you? (If Yes, provide specifics of the felony, dates of jail time, if any, and date probation ends or ended in the Remarks section.)	☐	☐
6. Have you had a driver's license suspended or revoked, or been convicted of three or more moving violations within the past five years? (If Yes, provide dates, type and state of issue in the Remarks section.)	☐	☐
7. Within the past five years, have you used or smoked tobacco and/or any other product containing nicotine in any quantity? (If Yes, provide details as to type of product and date last used in the Remarks section.)	☐	☐

Medical Information (For Yes answers, except for HIV, AIDS or ARC, provide diagnosis, treatment, test results, medications in the Remarks section.)

	Yes	No
1. What is your height? _____ 2. What is your weight? _____		
3. In the last five years, have you been examined or treated by a licensed medical practitioner, or been examined or treated at a hospital or other medical facility?	☐	☐
4. Except for Human Immunodeficiency Virus (HIV), have you ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for a disease or disorder such as:		
a. Chest pain, angina, congestive heart failure, heart disease, heart murmur, coronary artery disease, peripheral vascular disease, atrial fibrillation, high blood pressure, or other disorders of the heart or blood vessels?	☐	☐
b. Transient ischemic attack, stroke?	☐	☐
c. Asthma, emphysema, Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐
d. Cancer, leukemia, lymphoma?	☐	☐
e. Diabetes?	☐	☐
f. Cirrhosis, chronic hepatitis, diseases of the liver, pancreas, or kidney?	☐	☐
5. Within the last five years, have you ever been diagnosed, treated, or been given medical advice by a licensed member of the medical profession and/or taken medication for depression or any psychiatric or mental health disorder?	☐	☐
6. Other than as prescribed by a licensed member of the medical profession, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? If "Yes," also give name, form, amount, frequency and length of use, and date last used in remarks..	☐	☐
7. Have you ever received medical treatment or counseling for, or been advised by a licensed member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
8. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a licensed member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐

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Medical Certification

(Except for HIV, AIDS or ARC, give details of all medical examinations, consultations, or treatment that you have had within the last five years. If none, check this box ☐.)

Reason for Consultation, Examination or Treatment	Date	Duration	Result	Name and Address of Physician

In-Force Insurance Information

(Complete the chart below for any existing life insurance or annuity, if none check this box ☐.)

Policy/Contract #	Company	Face Amount	Issue Yr

Child Rider Information

(For each person listed, complete the Reinstatement Application for Child Rider form(s).)

Full Name of Person to be Covered	Date of Birth (mm/dd/yyyy)	Relationship

Remarks (Use this section for responses to Yes answers or to provide additional information.)

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Remarks (Use this section for responses to Yes answers or to provide additional information.)

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Name: First	MI	Last	Policy Number

Signatures

I hereby apply for reinstatement of the above policy. I represent that the foregoing answers and statements are true and complete to the best of my knowledge and belief. I understand that:

1. During the reinstatement consideration period, the policy will remain lapsed. No benefits will be payable, and any amount we receive will not earn any investment experience or interest.
2. If the policy is not reinstated, Pacific Life Insurance Company's (PLIC's) only liability in connection with this application shall be the refund of all sums tendered, without interest.
3. If the policy is reinstated but if any answers or statements contained herein are not complete and correct and would affect PLIC's decision to reinstate the policy, then PLIC's only liability for two years from the date of reinstatement shall be the refund of any amount paid to effect such reinstatement and all premiums paid thereafter less, any policy loans and any withdrawals taken, if applicable, after the reinstatement date.
4. If there was an outstanding loan at the time of policy lapse, other conditions may apply.
5. This application will be attached to and made part of the policy.

Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

If Proposed Insured or Policyowner is under age 18, a signature of parent/guardian is required in place of the minor's signature.

Signed In:

City	State

Signed and Dated On:

Date (mm/dd/yyyy)

X

Proposed Insured's Signature

Proposed Insured Name: First	MI	Last

X

Policyowner's Signature, if other than Proposed Insured, and include title if Corporation, Trust, or Business Entity

Policyowner's Name: First	MI	Last	Title