

[Policyholder Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Insurance Company Name]
[Reinstatement Department]
[Address Line 1]
[City, State, Zip Code]

RE: Statement of Good Health and Application for Reinstatement

Policy Number: [Policy Number]

Insured: [Your Full Name]

To Whom It May Concern,

I am writing to formally request the reinstatement of my Disability Income Insurance policy, which recently lapsed due to non-payment of premiums. Enclosed with this letter is the required premium payment in the amount of \$[Amount].

As part of this request, I am providing the following Statement of Good Health. I hereby certify that from the date the policy lapsed until the current date:

- My physical and mental health remains unchanged, and I continue to be in good health.
- I have not consulted any physicians, surgeons, or practitioners, nor have I been hospitalized or treated in any medical facility.
- I have not suffered any injury or illness that would impair my ability to perform the duties of my occupation.
- I have not applied for or received any disability benefits from any source.

I confirm that the representations made above are true and complete to the best of my knowledge. I understand that the insurance company relies on these statements to determine my eligibility for reinstatement.

Please process this reinstatement at your earliest convenience. Should you require any additional forms or medical authorizations, please contact me directly.

Sincerely,

[Signature]

[Printed Name]