

Date: [Insert Date]

Policy Number: [Insert Policy Number]

Insured Name: [Insert Name]

To [Insert Agency Name],

I, [Insert Name], am applying for the reinstatement of the above-referenced insurance policy which lapsed on [Insert Date of Lapse] due to non-payment of premiums.

I hereby certify that since the date the policy lapsed:

- I have remained in good health and free from any physical or mental disease, illness, or injury.
- I have not consulted, been examined, or been treated by any physician or medical practitioner.
- There has been no change in my personal or family medical history, occupation, or habits.

I understand that this statement is a material representation and that the reinstatement of my policy is contingent upon the truth of these statements. I enclose the required premium payment of [Insert Amount] to bring the account current.

Please process this reinstatement and notify me once the policy is active.

Sincerely,

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[Signature of Insured]

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[Print Name]