

Date: [Insert Date]

Policy Number: [Insert Policy Number]

Insured Name: [Insert Full Name]

Statement of Good Health and Application for Reinstatement

To [Insurance Company Name],

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

I hereby certify that to the best of my knowledge and belief:

- The insured person is currently alive and in good health.
- Since the date of the original application or the date the policy lapsed, the insured person has not suffered any illness, injury, or physical impairment.
- The insured person has not consulted a physician or received medical treatment since the policy lapsed.
- There has been no change in the occupation or habits of the insured person that would increase the insurance risk.

I understand that this statement is a material representation and that the company relies on this information to decide whether to reinstate the policy. I agree that if any of the statements above are found to be false, the company shall have the right to void the reinstatement.

Enclosed is the required premium payment in the amount of \$[Insert Amount] to cover the overdue balance.

Sincerely,

Signature of Policyowner/Insured

[Insert Printed Name]

[Insert Phone Number]