

Policy Reinstatement



Request to reinstate a terminated life insurance policy

If you have questions, contact Policy Services at 1-800-336-4538.

1. POLICY	
Insured Name (Last, First MI)	Policy Number
	Insured SSN

2. CONDITIONS OF REINSTATEMENT
<p>A life insurance policy that has been terminated due to non-payment of premiums or cash surrender may be reinstated according to the Terms and Conditions of that policy with the following conditions:</p> <ul style="list-style-type: none">• The cash surrender check has not been cashed.• The insured must meet current eligibility requirements, either as a member or dependent of a current member.• The insured must sign (below in block 3) confirming that his/her health has not changed since the policy lapse date.• Any premiums that would have been due if the policy had remained in force must be paid prior to reinstatement.• A two-year contestability period will apply to the dates the policy was lapsed. <p>TERM LIFE additional conditions:</p> <ul style="list-style-type: none">• This form must be received by Armed Forces Mutual within 30 days of termination. Otherwise the insured must apply for a new policy. <p>WHOLE LIFE additional conditions:</p> <ul style="list-style-type: none">• This form must be received by Armed Forces Mutual within 90 days of termination. Otherwise the insured may reinstate the policy within 3 years of termination by completing a Reinstatement - Medical form and passing medical underwriting requirements.• The cash value (before deduction of loans) at the time of termination must be repaid to Armed Forces Mutual.• Interest on the cash value and unpaid premiums during termination must be paid to Armed Forces Mutual at the current loan rate.

3. INSURED SIGNATURE	
I understand and agree to the conditions above and hereby request Armed Forces Mutual to reinstate this policy. I certify that, in the past 150 days, I have not had a change in health, been hospitalized for any reason nor have I seen a doctor for other than a minor illness.	
Insured Signature	Date Signed (mm/dd/yyyy)

4. OWNER SIGNATURE (complete only if Owner is not the Insured)	
Owner Name (Last, First MI)	Owner SSN/TIN
Mailing Address	
Email	Phone (<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work)
Owner Signature	Date Signed (mm/dd/yyyy)

For office use only		
Lapse Date (mm/dd/yyyy)	Reinstatement Date (mm/dd/yyyy)	Reinstatement Authorized By

When completed, email to: PolicyService@aafmaa.com or fax to: 1-888-210-4882.