



## APPLICATION FOR REINSTATEMENT/POLICY CHANGE

I/We hereby apply for reinstatement / policy change of **Policy No.** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Applicant-Owner's Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_ **Mailing Address:** \_\_\_\_\_

Agent's Code: \_\_\_\_\_ Payment: Php \_\_\_\_\_ OR #: \_\_\_\_\_ Date paid: \_\_\_\_\_

Documents Enclosed:  Full Medical Examination  Policy Contract  Others (Please specify) \_\_\_\_\_

### PART I. GENERAL INFORMATION

#### 1. Present Occupation

Insured / Owner	Occupation	Nature of Work	Company Name & Address
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

2. That since the issuance of said Policy, I/we HAVE NOT: a) received any threat on my/our life/lives; b) been a party to any administrative/civil/criminal case; c) made any application for life, accident or sickness insurance or for reinstatement thereof has been declined, postponed or modified in kind. Amount or rate: and that I/we HAVE NO pending application for life insurance.

**For exception/s, please specify.** \_\_\_\_\_

3. That within the next twelve (12) months I/we DO NOT intend to: a) change my/our occupation/s; b) work or reside outside the Philippines: c) become member/s of the Armed Forces or Police Force.

**For exception/s, please specify.** \_\_\_\_\_

4. That I/we HAVE NOT made during the past two (2) years, NOR do I/we intend to make within the next twelve (12) months, any aerial flights other than as passenger/s on scheduled commercial airlines.

**For exception/s, please specify.** \_\_\_\_\_

### PART II. Request for POLICY CHANGE (To be accomplished if request is for policy change)

Request Item(s)	To be Amended to		
	I	O	
<input type="checkbox"/> Correction of Age and/or Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>	Corrected Age _____ Corrected Date of Birth _____
<input type="checkbox"/> Change Policy Plan / Riders / Face Amount	Plan Riders	<input type="checkbox"/> ADDITION _____ <input type="checkbox"/> DELETION _____	Face Amount _____
<input type="checkbox"/> Change Effective Date	New Issue Date: _____		
<input type="checkbox"/> OTHERS (Please specify)	_____		

I/We hereby represent that the foregoing statements written in Part 1 of this form are true and correct and that I/we have fully stated all exceptions to each of the statements and that if no exceptions are listed in the blank space provided for such exceptions, it shall have the same force and effect as if the word "NONE" were written therein.

I/We agree that any payment made in connection with this application shall be considered as deposit only and shall not bind the company until this application is finally approved by the company during my/our lifetime and good health. If this application is disapproved, I/We also agree to accept the refund of all payments made, without interest.

I/We understand that the statements in this application shall form part of this insurance contract. I/We further understand that for reinstatement cases, the policy shall be contestable within two years from the approval of reinstatement application for fraud, concealment or misrepresentation of any material information.

DONE at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Signature of Witness/Agent                      Signature of Payor/Applicant-Owner                      Signature of Insured

\_\_\_\_\_  
Signature of Irrevocable Beneficiary                      Signature of Assignee

**NOTE: THE COMPANY MAY, AT ITS DISCRETION, DENY THIS APPLICATION OR REQUEST THE APPLICANT/S TO FURNISH ADDITIONAL EVIDENCE OF INSURABILITY.**

#### FOR HOME OFFICE USE ONLY

Approved by: \_\_\_\_\_ Office: \_\_\_\_\_ Date: \_\_\_\_\_  
HOME OFFICE ENDORSEMENT

#### AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

NO. \_\_\_\_\_

To whom it may concern:

I, in my personal capacity or as legal guardian of \_\_\_\_\_, authorize any person, insurance company, or entity to give Insular Life or its authorized representative all requested records and information of my or \_\_\_\_\_ hospitalization, consultation or treatment in its custody, and needed as requirements for my reinstatement/policy change application and/or for any transaction involving my insurance policy. A photocopy of this authorization shall be valid as the original.

Printed Name and Signature of Applicant-Owner \_\_\_\_\_

Printed Name and Signature of Insured \_\_\_\_\_

#### REVIVAL NOTICE

\_\_\_\_\_  
Date



# Insular Life

Dear Policyholder/s:

You will be happy to learn that your application for the reinstatement of your policy has been approved.

To assure yourself and your loved ones of continued protection under your policy, we urge you to remember your succeeding due dates so that you can pay your premiums on time.

Policy Number	Mode	Next Premium Due Date	Premium

For this particular premium, this letter serves as our Premium Notice which you can present when you make your payment.

Very truly yours,

Authorized Signatory

**NON-MEDICAL QUESTIONNAIRE**

To be accomplished by the Insured in a single life policy; by Insured and Payor in a policy with Payor's Rider

1. a. Insured's Full Name (First, Middle, Last)				h.. Payor's Full Name (First, Middle, Last)			
b. Permanent Residence				i. Permanent Residence			
c. Other Residence				j. Other Residence			
d. Date of Birth		f. Nationality		k. Date of Birth		m. Nationality	
e. Place of Birth		g. Race		l. Place of Birth		n. Race	
<b>UNDERLINE APPLICABLE ITEMS</b>				<b>Check Box</b>			
				<b>Insured</b>		<b>Payor</b>	
2. Have you ever been treated for or ever had any known indication of:				Yes		No	
				Yes		No	
a. Disorder of eyes, ears, nose or throat				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dizziness, fainting, convulsion, headache, speech defect, paralysis or stroke, mental or nervous disorder?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Chest pain, palpitation, rheumatic fever, heart murmur, heart attack, high blood pressure or other disorder of the heart or blood vessels? (If high blood pressure, give highest reading)?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, hepatitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, other disorder of the stomach, intestines, liver or gall bladder				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, breast, uterus, ovaries or other reproductive organs?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Diabetes, thyroid, or other endocrine disorders?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Deformity, lameness or amputation?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of skin, lymph glands, cyst, tumor or cancer?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Allergies, anemia or other disorders of the blood?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Excessive use of alcohol, tobacco or any drug dependence?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Any mental or physical disorder not listed above?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Other than above, have you							
a. Had a check-up, consultation, illness or surgery?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Been a patient in a hospital, clinic, sanitarium or other medical facilities?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Ever received any blood transfusion or blood product, or been refused as blood donor?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had Electrocardiogram, X-ray, Blood test, or other special tests?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Been advised to have diagnostic test, hospitalization or surgery which was not completed?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				o. Family History			
				LIVING		DEAD	
				Age	State of Health	Age at Death	Cause and year of death
				Father			
				Mother			
				Brothers			
				Sisters			
				Spouse			
				Children			
				4. a. Have you had any deferment, rejection or discharge from any outfit because of physical or mental condition? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				b. Have you ever requested or received pension or claimed benefits because of injury, sickness or disability? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				c. For Insured Height ___cms. or ___ ft. ___in. Weight ___kgs. or ___ lbs. For Payor Height ___cms. or ___ ft. ___in. Weight ___kgs. or ___ lbs. Loss of weight during the last 12 months? If so, how many kgs./lbs. and reason? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				d. Have you noticed or are you aware of any unusual changes or disorders in your present physical condition, persistent or recurrent fever, night sweats, or recurrent diarrhea? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				e. Are you now under observation or taking medicine or treatment? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				5. a. Have you been told you had AIDS, AIDS-related complex or condition? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				b. Have you received advice or treatment in connection with any of the above categories? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				c. Have you been tested positive for anti-bodies to the AIDS virus? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				6. FOR WOMEN ONLY:			
				a. Date of last menstruation? _____ 20 _____			
				b. Date of last delivery _____ 20 _____			
				c. Pregnant <input type="checkbox"/> Yes _____ months <input type="checkbox"/> No			
				d. Any caesarian section or abnormalities of pregnancies? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
				DETAILS OF "YES" answers. (PLEASE IDENTIFY QUESTION NUMBER. Include dates, diagnosis, duration, of illness, results of treatment or tests done and names and addresses of all attending physicians and medical facilities. Please attach additional sheet if necessary).			

Before signing below, I have read the above statements and answers and found them to be true and complete to the best of my knowledge, I agree that such statements and answers shall be part of the application and are made to induce The Insular Life Assurance Company, Ltd. to reinstate/amend my policy. In this connection, I expressly waive my rights under all provisions of the law forbidding any physician, hospital employee or any person whom I consulted or who treated, examined or otherwise attended to me and I expressly authorize such persons to make known the nature of such consultation, examination, treatment and attendance and to make my records available.

I agree that should I hereafter apply to the Company for additional insurance, this application, and all the statements herein made by me shall, together with other evidence of insurability that the Company may require, be the basis for the issuance of said additional insurance.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

Witness \_\_\_\_\_

Signature of Agent

Signature of Applicant-Owner/Parent

Customer Signature of Proposed Insured