

APPLICATION FOR REINSTATEMENT

IMPORTANT NOTE: The reinstated Policy will cover eligible medical expenses only resulting from any Injury as may occur after the reinstatement date, and due to an Illness that begins more than 10 days after such date.

Policy No.: _____

Name of Policyholder: _____

Address: _____

Name of Insured Person: _____

Telephone No.: _____

Email: _____

Remarks: _____

I/We hereby declare that, to the best of my knowledge and belief, the below answers are true and accurate, and all information has been disclosed (please provide details on the space below or on a separate piece of paper).

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you have any current medical problems or symptoms for which you need to seek medical advice or treatment? if yes please state full details. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the time from the <u>first</u> health policy/rider issue date until now, have you had any medical treatment, diagnosis, or tests for which has not been disclosed to the Insurance company? if yes please state full details, including all dates, diagnosis, results, and ongoing treatment. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you incurred any medical expenses which have not yet been fully disclosed to the Insurance company? if yes please state full details, including the date of treatment, diagnosis, amount of money. | <input type="checkbox"/> | <input type="checkbox"/> |

Details: _____

Signature of Insured: _____ Date (day/month/year): _____