Manulife

APPLICATION FOR REINSTATEMENT

STATEMENT PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CHAPTER 142) , YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.

Please remember to...

- Countersign any amendments
- ☑ Ensure that the appropriate boxes are checked
- Note that Submission Cut-off time is 3pm

And for Corporate Policies...

- ✓ Enclose photocopies of NRIC/Passport of authorised signatories
- ✓ Enclose copy of the latest ACRA business profile extracted not more than 3 months from submission date

1 POLICY INFORMATION

Full Name of Owner .... NRIC/Passport No. ....

Policy Number ....

2 NAME(S) OF INSURED PERSON(S)

A Life Insured ....

B Payor ....

C Payor's Spouse/Other Insured ....

For more than 1 Other Insured(s), please attach additional Reinstatement Form

3 HEALTH DECLARATION OF INSURED PERSON(S)

- **Statement of Insurability is declared by Life Insured and Owner. However, if the Life Insured is under 16 years old, the Owner will be making the declaration.**
- **If a material fact is not disclosed in this form, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Representative but was not included in the form. Please check to ensure you are fully satisfied with the information declared in this form.**

	A Life Insured	B Payor	C Payor's Spouse / Other Insured
1a. **Please provide your current Height.**	____ m	____ m	____ m
1b. **Please provide your current Weight.**	____ kg	____ kg	____ kg
1c. **Has your weight changed in the last 12 months?** *If Yes, please provide the following details.*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Insured Person	Weight Change	Reason
A	☐Gain ☐Loss ________ kg	
B	☐Gain ☐Loss ________ kg	
C	☐Gain ☐Loss ________ kg	

	A Life Insured	B Payor	C Payor's Spouse / Other Insured
2a. **Since the inception of the Policy, has there been any change in your health status, occupation or country of residence?** *If Yes, please provide the following details.*	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Insured Person	Change	Details
A	☐Health Status ☐Occupation ☐Country of Residence	
B	☐Health Status ☐Occupation ☐Country of Residence	
C	☐Health Status ☐Occupation ☐Country of Residence	

RI-1018

INTERNAL USE - FOR REPRESENTATIVE

Submitted by ☐Servicing Rep ☐Others ________________(Code)

INTERNAL USE - FOR STAFF

Doc ID ☐PA019 ☐______ ☐Approved By ____________________

	A Life Insured	B Payor	C Payor's Spouse / Other Insured

2b. Have you ever been deferred or declined for Life, Critical illness, Accident, Health insurance, offered insurance with restricted benefits or other than at standard rates?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

If Yes, please provide the following details.

Insured Person	Insurance Company	Details
A		
B		
C		

2c. Since the inception of the Policy, have you engaged in or do you intend to engage in any hazardous pastimes or activity e.g. parachuting, hang gliding, motor sport of any kind (car, boat, motor cycle, go kart), underwater diving, rock climbing, mountaineering and/or flying other than as a fare paying passenger on a licensed commercial airline?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

If Yes, please provide the following details and complete the relevant questionnaire.

Insured Person	Activity/Avocation
A	
B	
C	

2d. Since the inception of the Policy, have you travelled outside of Singapore other than for holidays?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

If Yes, please provide the following details.

Insured Person	Reason	City	Country	Duration
A	☐Business ☐Personal ☐Residing			
B	☐Business ☐Personal ☐Residing			
C	☐Business ☐Personal ☐Residing			

2e. Are you in the process of filing a claim or have you ever made a claim against any insurance company in respect of any Disability, Critical Illness, Medical, Hospitalization, Accident or Life insurance?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

Insured Person	Insurance Company	Type of Plan	Description of Claim	Date of Claim	Claim Amount
☐A ☐B ☐C					
☐A ☐B ☐C					
☐A ☐B ☐C					

2f. Do you have any symptom or medical concern for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not been completed?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

2g. Are you planning or have been advised to have a medical check up, surgery or be hospitalized?

A: ☐Yes ☐No | B: ☐Yes ☐No | C: ☐Yes ☐No

If any of the answers to Question 2f & g is "Yes", please indicate the Question number, respondent and provide details below.

Question	Insured Person	Condition/ Diagnosis	Year at onset	Test performed, dates & results	Treatment & Medication	Doctor/Hospital/ Clinic consulted
	☐A ☐B ☐C					
	☐A ☐B ☐C					

RI-1018

4 DECLARATION & AUTHORISATION

1. I/We declare that no material facts, that is facts likely to influence the assessment of this Application for Reinstatement have been withheld and to the best of my/our knowledge and belief the information given here is true and complete.
2. I agree to inform Manulife if there is any change in the state of health, occupation or activity of the Insured between the date of this application or medical examination and the issue of the above benefit. On receiving the information of any change, Manulife is entitled to accept or reject my application.
3. I/We have read the Section 25(5) Insurance Act (Cap 142) warning stated on this Form.

Signature of Owner/Assignee

Name ....

Contact No. .... **Date** ....

Signature of Life Insured (16 years and above)

Name ....

Contact No. .... **Date** ....

Signature of Payor

Name ....

Contact No. .... **Date** ....

Signature of Payor's Spouse/Other Insured

Name ....

Contact No. .... **Date** ....

Additional Authorisation for Policy under a Trust

Section 49L (Insurance Act)

- **Who to sign:**
  Any Trustee of the policy who is not the Owner
  OR all Beneficiaries 18 years and above
  Trustee can be appointed by the Owner via Nomination of Beneficiary Form 3
- **Proceeds payable to:**
  Trustee(s) **OR** All Beneficiary(ies)

Section 73 (Conveyancing & Law of Property Act)

- **Who to sign:**
  All Trustee(s) of the Policy
- **Proceeds payable to:**
  Trustee(s) for the benefit of the Beneficiary(ies)

Signature of Trustee/Beneficiary

Name .... Date ..../..../....

NRIC No. .... Contact No. ....

Signature of Trustee/Beneficiary

Name .... Date ..../..../....

NRIC No. .... Contact No. ....

Signature of Trustee/Beneficiary

Name .... Date ..../..../....

NRIC No. .... Contact No. ....

Signature of Trustee/Beneficiary

Name .... Date ..../..../....

NRIC No. .... Contact No. ....

RI-1018

If you wish to understand the list of purposes for which your personal data may be used or disclosed, you may refer to the Statement of Personal Data Protection located at our website (www.manulife.com.sg)

Need Help? Please contact your **Financial Representative** for further assistance.
Alternatively, you may call our **Client Services Officers** at **6833 8188** or visit us at **8 Cross Street #01-01A, Manulife Tower, Singapore 048424** during service hours.

Completed? You may submit the completed and signed form with all relevant documents to us through:
Mail –**8 Cross Street #15-01, Manulife Tower, Singapore 048424**