



**STATEMENT OF INSURABILITY/
APPLICATION FOR REINSTATEMENT**

STATEMENT OF INSURABILITY FOR REINSTATEMENT OR POLICY CHANGE

POLICY NUMBER/S		LAPSE DATE/S	
NAME OF LIFE INSURED		ATTAINED AGE	BIRTHDATE
NAME OF ANY PAYOR/OWNER		ATTAINED AGE	BIRTHDATE
LIFE INSURED'S RESIDENCE ADDRESS		LIFE INSURED'S BUSINESS ADDRESS	
HEALTH DECLARATION		NO	YES
Number the answer to correspond to the question. Give full particulars, condition, dates, duration, results. Give full names and addresses of doctors, hospitals, clinics. State name of person referred to.			
1. Is the Life Insured or Payor/Owner in good health?			
2. Is the Life Insured or Payor/Owner actually at work or is physically able to discharge fully his/her duties or responsibilities in the life work he/she is presently engaged in?			
3. Since this Policy was initially approved or from its last reinstatement; has the Life Insured or Payor/Owner:			
a) had any illness, injury, operation, treatment or consulted, been advised or examined by any doctor or other medical practitioners except as required by Manulife?			
b) changed his/her occupation, country of residence or aviation activities?			
c) had any new application of insurance or existing policy/ies with other company/ies on his/her life declined postponed or offered or reinstated with restricted benefits at other than standard rates?			
4. Height _____ Weight _____			
5. Will anyone other than the Insured/Owner be paying for this policy?			
6. Has the Insured/Owner or any direct relative of either person ever held a senior position in the government, a political party, the military, any tribunal or government-owned corporation?			
1. The life insured and any payor/owner declare that "we have read the statements and answers in the above Health Declaration and, to the best of our knowledge and belief, they are complete and true".			
2. MANULIFE PHILIPPINES is requested to reinstate the above-numbered policy. It is agreed that except from non-payment of premiums or any other grounds recognized by the law and jurisprudence, the Company cannot contest this policy after it has been in force during the lifetime of the insured for two (2) years from its date of last approved reinstatement. This incontestability period will not apply to supplementary contracts relating to benefits payable in the event of total disability and benefits which grant additional insurance specifically against death by accidental means.			
NAME AND SIGNATURE OF LIFE INSURED		NAME AND SIGNATURE OF PAYOR/OWNER	
NAME AND SIGNATURE OF AGENT/WITNESS		AGENT'S CODE NUMBER	
PLACE SIGNED		DATE SIGNED	
APPROVED BY		DATE SIGNED	

FORM No. PS009 (1000)

AUTHORIZATION (ADULT)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give MANULIFE PHILIPPINES and its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is in connection with the reinstatement/policy change of my policy only.

Signature of Life Insured _____

Signature of Witness _____

Date _____

AUTHORIZATION (CHILD)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of him or his health, to give MANULIFE PHILIPPINES and its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. This authorization is in connection with the reinstatement/policy change of my policy only.

Signature of Life Insured _____

Signature of Witness _____

Date _____