Manulife

APPLICATION FOR REINSTATEMENT (Plans)

1. General Information

Name of Life Insured (Last, First, MI) | Place of birth | Citizenship

Name of Policy Owner, if different from Life Insured, (Last, First, MI) | Place of birth | Citizenship

Mailing Address | Policy Number

Address Abroad (If applicable) | Email Address

Telephone No./Mobile | Telephone No. Abroad (if applicable) | Occupation | TIN

2. Declarations and Representations

Reinstatement is for ☐ **Updating** ☐ **Redating**

Conditions:

Upon approval of this request, I hereby agree that the reinstatement of my Plan shall be subject to the following conditons:

a. That the provision of contestability shall apply anew for one year from the approval date of reinstatement for all affected insurance coverages
b. That the reinstatement of my insurance coverage is based exclusively on the statements of my health condition which I declare to be true and correct.

I hereby declare and represent to the best of my knowledge that:

a. I am note below 18 years old nor more than 65 years and 6 months old.
b. I have not been confined in any hospital, sanitarium or infirmary nor received medical or surgical treatment in the last twelve (12) months.
c. I have never had or been treated for the heart condition, high blood pressure, blood disease, cancer, mass, tumor, abnormal bodily growth, diabetes, lung, kidney or stomach disorder or any other injury or physical impairment in the last five (5) years.
d. I am in good health and physical condition.
e. (For females) I am not pregnant.

NOTE: If any of the above declarations and representations are not applicable to you, please give details below.

specify dates, attending physician's name, hospital or clinic diagnoses and treatment, etc.

f. The total non-medical insurance coverage under this application and of any other application under this and other Group Insurance Policy covering pre-need contracts/agreements issued by Manulife Financial Plans in my name does not exceed the Non-Medical Limit set forth in the Group Insurance Master Policy issued by The Manufacturer's Life Insurance Company (Philippines), Inc. to Manulife Financial Plans.

Otherwise, I agree that the individual insurance under this and other Group Insurance Policy for these and other pre-need contracts agreements in excess of the Non-Medical Limit will be without insurance coverage unless I undergo a medical examination and found acceptable in accordance with the underwriting rules prescribed by the aforementioned insurance company.

Plan type/s and count of previously issued contracts/agreements, if any: _____

g. Will anyone other than the Insured/Owner be paying for the policy? ☐ **Yes** ☐ **No**

h. 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? ☐ **Yes** ☐ **No**

I agree that the insurance coverage herein applied for is based on the truth of the foregoing declarations and is subject to the provisions of the Group Insurance Master Policy issued by the Manufacturer's Life Insurance Company (Phils.), Inc. to Manulife Financial Plans. I further agree that if the above is left blank or if there be any concealment, fraud or misrepresentation in the above statements material to the risk, the insurance company shall have the right to declare such insurance null and void, subject to the incontestability clause of the Group Master Policy.

I further agree that this application, including the declaration and answers given shall be the basis of the contract between Manulife Financial Plans and myself, and shall be deemed part thereof.

I understand that if I am eligible, my insurance coverage shall take effect on the earlier date of either the Provisional Receipt or the Official Receipt of the initial installment for my education plan and term life rider, if any, provided I have signed the application form, have paid the corresponding installment due and was, in the opinion of the life company's authorized officers, insurable as a standard risk as of that date.

Requirements:
Duly filled out Reinstatement form
Photocopy of Two (2) Valid IDs

Notes:
If Plan Holder is more than 51 years old, Non-Medical Form is also required.
**Additional requirements may be requested depending on the Underwriting evalaution*

3. Signatures

Date signed | Place signed

Name and signature of Plan Holder | Name and signature of Plan Owner/Payor

Name and signature of Agent/Witness | Agent's Code

The Manufacturers Life Insurance Co. (Phils.) Inc.
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