The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I VAT REG. TIN 000-464-124-000

Application for Reinstatement / Policy Change

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

Insured's Name: _____ **Policy Owner/Payor'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	Payor	Occupation	Nature of Work	Company Name & Address
☐	☐			
☐	☐			
☐	☐			
☐	☐			

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 exceptions, please give details.** _____
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 exceptions, please give details.** _____
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: a) any aerial flights other than as passenger/s on scheduled airlines; b) engage in any car/motorcycle/motorboat racing, sky/scuba diving, or other hazardous activities/ sports/habits; c) run for any public office. **For exceptions, please give details.** _____

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

Request Item(s)	To be Amended to			
Codes: I- Insured P-Payor	**I**	**P**	**Corrected Age**	**Corrected Date of Birth**
☐ Correction of Age and/or Date of Birth	☐	☐		
	☐	☐		
☐ Change Policy Plan / Riders / Face Amount	Plan Riders		☐ ADDITION _____ ☐ DELETION _____	Face Amount _____
☐ Change Effective Date	New Issue Date:			
☐ 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.

Further, I/We understand and agree that:

1. 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, any amount deposited will be refunded to me/us without interest.
2. The statements in this application shall form part of this insurance contract and the policy shall be contestable within two years from the approval of reinstatement application for concealment or misrepresentation of any material information.
3. I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

   In this connection, I authorize Insular Life to process my personal and sensitive personal information (also known as personally identifiable information or PII) including the collection, usage, storage, retention, and disclosure of my PII in the related processes and systems until its disposal. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents, medical information sharing facility of the insurance industry and third parties for any legitimate purpose, including the underwriting and administration of insurance coverage and claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audits, and such activities for which my PII may be required in fulfillment of mandated services across my entire life stages.

   I/We also confirm that I/we have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

   I hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction or sharing of said information.

DONE at _____ this _____ day of _____, 20 _____

Signature of Witness/Agent	Signature of Policy Owner/Payor	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

Non-Medical Questionnaire

PART II – APPLICATION FOR FOR REINSTATEMENT/POLICY CHANGE TO THE INSULAR LIFE ASSURANCE CO., INC.

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

1. a. Insured's Full Name (Given Name, Surname, Suffix		2. a. Payor's Full Name (Given Name, Surname, Suffix	
b. Primary Address		b. Primary Address	
c. Secondary Address		c. Secondary Address	
d. Date of Birth	f. Nationality	d. Date of Birth	f. Nationality
e. Place of Birth	g. Gender ☐ F ☐ M	e. Place of Birth	g. Gender ☐ F ☐ M

3. Have any of your Parents and/or siblings been diagnosed of any illness or medical condition/s? ☐ YES ☐ NO. If Yes, please give details on the table below.

Complete Name of Family Member	Relationship to Insured	Relationship to Owner/Payor	Condition/Illness	Estimated Age at onset of Illness	Age and cause of Death (if applicable)

4. Build : Owner/Payor: Height: _____ cm or ___ ft ____ in Weight _____ kgs or _____ Lbs
Insured: Height: _____ cm or ___ ft ____ in Weight _____ kgs or _____ Lbs

5. Have you ever had or been suspected of any of the following:	Payor YES	Payor NO	Insured YES	Insured NO
a. Disorder of the eyes, ears, nose, or throat?	☐	☐	☐	☐
b. Dizziness, fainting spells, convulsion, epilepsy, chronic headache or migraine, numbness, speech defect, paralysis, stroke, depression, anxiety disorder or any psychiatric disorder?	☐	☐	☐	☐
c. Congenital heart disease, heart murmur, heart attack, chest pain, palpitations, shortness of breath, swelling of ankles, other disorder of the heart and blood vessels or high blood pressure?	☐	☐	☐	☐
d. Asthma, chronic bronchitis, TB, spitting of blood, pleurisy, emphysema or any respiratory disorder?	☐	☐	☐	☐
e. Jaundice, hepatitis, found to be positive for Hepatitis virus, persistent/recurring indigestion, gastric/duodenal ulcer or any disease of the stomach, intestines, pancreas or liver?	☐	☐	☐	☐
f. Diabetes Mellitus, thyroid or other endocrine disorders?	☐	☐	☐	☐
g. Urinary tract infection, disorder of the kidney, bladder, prostate, ureter or the male/female reproductive organ?	☐	☐	☐	☐
h. Neuritis, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joint, deformity, lameness or amputation?	☐	☐	☐	☐
i. Anemia, bleeding or other disorder of the blood or have received blood transfusion?	☐	☐	☐	☐
j Cyst, cancer or tumor/growth of any kind and other disorder of the skin?	☐	☐	☐	☐
k. Systemic Lupus Erythematosus, rheumatic fever, rheumatoid arthritis, Kawasaki disease or any disorder of the immune system?	☐	☐	☐	☐
6. Have you experienced any symptoms or change in your present physical condition such as persistent pain, swelling, persistent or recurrent fever, night sweats, recurrent diarrhea and frequent urination, or any other illness and disorder, which have not been evaluated or treated by a doctor?	☐	☐	☐	☐
7. For the last 5 years:				
a. Have you ever sought consultation or advice for health or medical reasons or been treated or confined in a hospital, sanitarium or similar institution?	☐	☐	☐	☐
b. Have you had ECG, CXR, Treadmill Stress Test, 2D Echocardiogram, blood test, other diagnostic procedures?	☐	☐	☐	☐
c. Have you ever been advised to have diagnostic test, hospitalization, or surgery which was or was not completed?	☐	☐	☐	☐
8. Are you now under observation, undergoing treatment, taking medication or herbal supplements/medicines, reducing or diet pills?	☐	☐	☐	☐
9. Has your weight changed during the last 12 months? If so, how many kgs./lbs., and give reason. Gain(kgs/lbs)_____ Loss (kgs/lbs)_____	☐	☐	☐	☐
10. Have you ever been tested positive (+) for HIV, AIDS or had any form or been treated for other sexually transmitted diseases?	☐	☐	☐	☐
11. a. Do you smoke cigarette/tobacco? If yes, please specify: Type _____ Daily Consumption _____ No of Yrs Smoked _____	☐	☐	☐	☐
b. Have you ever smoked cigarette/tobacco? If yes, please specify: Type _____ Daily Consumption _____ No of Yrs Smoked _____ Date Stopped_____	☐	☐	☐	☐
12. a. Do you take alcoholic drinks? If yes, please specify: Type _____ Frequency and amount (e.g. per day/per week, no. of bottles or shots) _____	☐	☐	☐	☐
b. Have you ever taken alcoholic drinks? If yes, please specify: Type _____ Frequency and amount (e.g. per day/per week, no. of bottles or shots) _____ Date Stopped_____	☐	☐	☐	☐
13. Have you ever taken drugs such as narcotics, hallucinogens, stimulants or sedatives which were not prescribed by a doctor?	☐	☐	☐	☐
14. Do you have a family/regular doctor? If yes, please provide full name, contact number, complete clinic address.	☐	☐	☐	☐
15. FOR WOMEN ONLY: a. Date last menstruated? _____ b. Date of last delivery? _____ c. If pregnant, how many months? _____ d. Any miscarriage/caesarian section or abnormalities of pregnancies?	☐	☐	☐	☐
16. FOR INSURED UNDER two (2) years old: a. Birth Weight _____ kgs _____lbs b. Did the child stay in the hospital for more than 5 days? If yes, why?			☐	☐
c. Did he/she have any birth problem, blood incompatibility, congenital problem or deformity, or lack of mental or physical development?			☐	☐

DETAILS OF "Yes" ANSWERS (Please *Identify question number and include dates, diagnosis, duration of illness, results of treatment or tests done, and name and addresses of all Attending Physicians and medical facilities. Use separate 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 to the extent permitted by law.

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 such 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 over Printed Name of Policy Owner/Payor/Parent	Customary Signature over Printed Name of Insured

IL20190228-1

AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

In connection with my application for a life insurance policy with The Insular Life Assurance Co., Ltd. ("Insular Life") or with any matter relating to that insurance policy, if issued,I hereby authorize and request you or any physician, surgeon, hospital, clinic, insurance company, or other organizations to give Insular Life or its authorized representative, any and all information regarding my health, sickness or disease, injury, medical history, including any and all records of my hospitalization, consultation, diagnosis, treatments which you/they may have acquired in attending to me in your/their professional capacity. A photocopy of this authorization shall be valid as the original.

Printed Name and Signature of Payor/Policy Owner	Printed Name and Signature of the Insured