



Application for Reinstatement / Policy Change

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

Insured's Name: _____ **Applicant-Owner'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 / Owner | Occupation | Nature of Work | Company Name & Address |
|--------------------------|--------------------------|----------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | _____ | _____ |
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		
	I	O	
<input type="checkbox"/> Correction of Age and/or Date of Birth	<input type="checkbox"/>	<input type="checkbox"/>	Corrected Age _____ Corrected Date of Birth _____
<input type="checkbox"/> Change Policy Plan / Riders / Face Amount	Plan Riders <input type="checkbox"/> ADDITION _____ <input type="checkbox"/> DELETION _____		Face Amount _____
<input type="checkbox"/> Change Effective Date	New Issue Date: _____		
<input type="checkbox"/> 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.

I/We agree that 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.

I/We understand that the statements in this application shall form part of this insurance contract. I/We further understand that for reinstatement cases, the policy shall be contestable within two years from the approval of reinstatement application for concealment or misrepresentation of any material information.

DONE at _____ this _____ day of _____, 20_____

Signature of Witness/Agent Signature of Payor/Applicant-Owner 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



**Insular
Life**

Non-Medical Questionnaire

PART II – APPLICATION FOR INSURANCE 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. Proposed 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 <input type="checkbox"/> F <input type="checkbox"/> M	e. Place of Birth	g. Gender <input type="checkbox"/> F <input type="checkbox"/> M			
3. Have any of your Parents and/or siblings been diagnosed of any illness or medical condition/s? <input type="checkbox"/> YES <input type="checkbox"/> NO. If Yes, please give details on the table below.						
Complete Name of Family Member	Relationship to Proposed Insured	Relationship to Applicant Owner	Condition/Illness	Estimated Age at onset of Illness	Age and cause of Death (if applicable)	
4. Build : Applicant Owner: Height: _____ cm or _____ ft _____ in Weight _____ kgs or _____ Lbs				Proposed Insured: Height: _____ cm or _____ ft _____ in Weight _____ kgs or _____ Lbs		
5. Have you ever had or been suspected of any of the following:				Applicant Owner	Proposed Insured	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)
a. Disorder of the eyes, ears, nose, or throat?				YES NO	YES NO	
b. Dizziness, fainting spells, convulsion, epilepsy, chronic headache or migraine, numbness, speech defect, paralysis, stroke, depression, anxiety disorder or any psychiatric disorder?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
d. Asthma, chronic bronchitis, TB, spitting of blood, pleurisy, emphysema or any respiratory disorder?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
e. Jaundice, hepatitis, found to be positive for Hepatitis virus, persistent/recurrent indigestion, gastric/duodenal ulcer or any disease of the stomach, intestines, pancreas or liver?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
f. Diabetes Mellitus, thyroid or other endocrine disorders?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
g. Urinary tract infection, disorder of the kidney, bladder, prostate, ureter or the male/female reproductive organ?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
h. Neuritis, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joint, deformity, lameness or amputation?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
i. Anemia, bleeding or other disorder of the blood or have received blood transfusion?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
j. Cyst, cancer or tumor/growth of any kind and other disorder of the skin?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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, which have not been evaluated or treated by a doctor?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
b. Have you had ECG, CXR, Treadmill Stress Test, 2D Echocardiogram, blood test, other diagnostic procedures?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
c. Have you ever been advised to have diagnostic test, hospitalization, or surgery which was or was not completed?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
8. Are you now under observation, undergoing treatment, taking medication or herbal supplements/medicines, reducing or diet pills?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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) _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
10. Have you ever been tested positive (+) for HIV, AIDS or had any form or been treated for other sexually transmitted diseases?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
11. a. Do you smoke cigarette/tobacco? If yes, please specify: Type _____ Daily Consumption _____ No of Yrs Smoked _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
b. Have you ever smoked cigarette/tobacco? If yes, please specify: Type _____ Daily Consumption _____ No of Yrs Smoked _____ Date Stopped _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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) _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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 _____				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
13. Have you ever taken drugs such as narcotics, hallucinogens, stimulants or sedatives which were not prescribed by a doctor?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
14. Do you have a family/regular doctor? If yes, please provide full name, contact number, complete clinic address.				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
16. FOR PROPOSED 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?				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
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 Applicant-Owner/Parent _____ (if Proposed Insured is below 18 yrs. old)		
				Customary Signature over Printed Name of Proposed Insured _____		

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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/Applicant-Owner

Printed Name and Signature of the Proposed Insured