Application for Reinstatement and/or Declaration of Good Health and Insurability

Sun Life Financial

Please PRINT clearly.
Use BLACK ink.

In this form, *you* and *your* refer to the planholder and, where applicable, also the person being insured, while *we*, *us*, *our* and *the Company* refer to Sun Life Financial Plans, Inc., a member of the Sun Life Financial group of companies. *Insurance Provider contracted by Sun Life Financial Plans, Inc.* refers to Sun Life of Canada (Philipppines), Inc., also a member of the Sun Life Financial group of companies.

Application/Declaration by (Name of Planholder/person being insured)	For the ☐ Reinstatement ☐ Amendment
under Plan No.	

1 General Information

Please provide complete address; do not use P.O. box.

Name of Planholder/Person being insured (Last, First, Middle)		Birthdate (day/month/year)	Age
Residence Address (no., street, municipality, city/province)			
Mailing Address (no., street, municipality, city/province)			
Home Phone No.	Business Phone No.	Cell Phone No.	E-Mail Address
If address is outside the Philippines, since when? (day/month/year)		Occupation - please indicate specific job	
Have you changed your occupation since the date of application for your pre-need plan ? ☐ Yes ☐ No If "Yes", since when? (day/month/year)			

2 Details of Request

a. For Reinstatement (Please mark the appropriate box with an "X")

☐ Updating: You have to pay all overdue installments with interest.

☐ Redating: You have to pay one installment based on the new price, if any, plus any charges. (You may choose Redating if you have more than one installment to pay to reinstate your Plan.)

Does the above-numbered plan being reinstated have insurance benefits? ☐ Yes ☐ No
(If "Yes", complete Section 3)

b. For Amendment (Please mark the appropriate box with an "X" and complete Section 3)

☐ Addition of Insurance Rider, optional:

_____

☐ Others, please specify

_____

c. Payment Information

☐ Cash

☐ Cheque (Bank & Cheque No.)

_____

Amount

_____

3 Declarations and Representations

Complete this section if
a) the plan you are reinstating is issued **with insurance benefits** and if your age is not more than 65;
b) your request is under Section 2 b. - for amendment.

If you answer "yes" to questions 1 (a, b, c, d, & e) and 2, please provide details on the next page. (Use separate sheet if necesary)

1. Within the past 2 years(or since the date of application for this plan or its last reinstatement, if more recent), have you:
   a) applied for any life or health reinsurance which had been declined, postponed, rated or accepted on a basis other than applied for? ☐ Yes ☐ No
   b) been examined for, or treated for high blood pressure, stroke, heart disorder, diabetes, cancer or tumor, chest pain, or had such treatment been recommended by a physician or other practitioner? ☐ Yes ☐ No
   c) consulted any physician or other health practitioner? ☐ Yes ☐ No
   d) been told you had, or sought advice for any illness, disease or injury? ☐ Yes ☐ No
   e) submitted to ecg, x-ray, urine, blood tests or other tests, which resulted in abnormal findings? ☐ Yes ☐ No
2. Are you presently disabled by illness or injury or otherwise prevented from performing on a full time basis any of the duties of your occupation? ☐ Yes ☐ No

3 Declarations and Representations (continued)

Question	Date	Reason for Visit/Check-up	Name & Address of Doctor, Laboratory or Hospital	Medication, Advice or Treatment	Results

4 Signatures

This application must be signed by you.

By signing below, you hereby declare that to the best of your knowledge and belief the above answers are full and true and agree that:

1. this application if approved, with the answers given in any other declaration which maybe required by the Company and the Insurance Provider, and which relates to your insurability, shall be the basis of such request for reinstatement or amendment.
2. the Company and the Insurance Provider, if appropriate, shall incur no liability by reason of this application or by reason of any cash paid or settlement made in connection herewith, until this application has been approved by the Company and the Insurance Provider, if appropriate, with no change having taken place in your insurability subsequent to the date of this application.
3. in the event that you are not found eligible for insurance, that amount which you shall have paid in connection with this application shall be treated merely as a deposit to be refunded to you upon notice of non-acceptance and disapproval. In cases of application for reinstatement, should you still wish to reinstate the plan despite your ineligibility for insurance, the plan will continue with no insurance coverage.
4. in case of reinstatement by redating, you agree to the change of the final installment date and/or maturity date of the pension benefit/education benefit.
5. in cases of application for reinstatement, the one year contestability period shall start again on the date of the approval of such reinstatement.

Signature of Planholder/Person being insured X	Printed Name
Signature of Witness X	Printed Name
Place of Signing	Date of Signing (day/month/year)

Authorization

You hereby authorize any physician, hospital, clinic, insurance company or other organization, institution, or person, that has any record of you or your health, to give to Sun Life of Canada (Philippines), Inc., the Insurance Provider contracted by Sun Life Financial Plans, Inc., any and all information about you with reference to your health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A copy of this authorization will be as valid as the original.

Signature of Planholder/Person being insured X	Printed Name
Signature of Witness X	Printed Name
Place of Signing	Date (day/month/year)