



POLICY REINSTATEMENT APPLICATION

Company Name: _____

Name of Insured: _____

Job Title: _____

Date of Birth (dd/mm/yy): _____ Gender (M/F): _____ Height (cm): _____ Weight (kg): _____



DEPENDANTS

Name	Date of Birth	Gender	Height/Weight	Relationship	Occupation

1. Have you or any of your dependants consulted a physician in the past 2 years?

- Yes (please explain): _____
- No

2. Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition?

- Yes (please explain): _____
- No

3. Have you or any of your dependants been advised to undergo any test, treatment, special diet, medication, procedure, check-up, or hospitalisation?

- Yes (please explain): _____
- No

4. Do you have any pending claims?

- Yes (please explain & state amount): _____
- No

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true.

Signature of the Insured / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date

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