REINSTATEMENT APPLICATION

REINSTATEMENT TYPE:
□ Basic
□ Campaign

SECTION A – POLICY & CLIENT DETAILS

Policy Number/s:	**Date of Lapse:** *(DD-MMM-YYYY)*	**□Mr. □ Mrs. □ Miss □ Ms.**
Name of Proposed Life Insured *(First, Middle, Last)*		**Maiden Name**
Date of Birth *(DD-MMM-YYYY)*	**Age** / **Sex**	**Marital Status**
Country of Birth		**ID Number**
I.D. Type: Passport □ Voter's Card □ Driver's License □ Birth Certificate □ Other □ _____		**I.D. Expiry** *(DD-MMM-YYYY)*
Occupation	**Employer** *(Company Name)*	
Current Address		
Email Address	**Telephone Number**	
Name of Policy Owner *(First, Middle, Last)*		

SECTION B – REINSTATEMENT QUESTIONNAIRE – ***must*** *be completed by insured, unless insured is a minor.*

	YES	NO
Name of your current physician: / **Date last seen** *(DD-MMM-YYYY)*		If "YES", give details in Section D
1. Current height and weight? Height_____ ft _____in Weight _____ lbs		
2. Has your weight changed in the last year?	□	□
3. Have you or your partner ever had, sought consultation for, been tested for or told that you have HIV, AIDS (Acquired Immune Deficiency Syndrome), A.R.C. Aids Related Complex) or any immunological disorder OR any form of Cancer?	□	□
4. Are you in good health?	□	□
5. Have you ever been seen by a physician, or had a clinic or hospital visit?	□	□
6. Are you now on any medications or under treatment?	□	□
7. Have you ever been advised to take any test, surgery, treatment, or medication?	□	□
8. Have you suffered any illness or received any medical advice or attention since the date of issue of the above numbered policy? If so, state the nature of the illness, date, duration and name of Physician.	□	□
9. Have you ever used narcotics, marijuana, alcohol or other habit-forming drugs / substances?	□	□
10. Have you smoked/used cigars, cigarettes, e-cigarette, hookah, vape, tobacco or nicotine in any form within the past 12 months?	□	□
11. Have you ever been arrested, charged or convicted of any criminal offense, traffic violations or do you have any charges pending? *If yes please provide details*	□	□
12. Have you ever been rated, postponed, declined, or offered coverage other than as applied for?	□	□
13. Do you intend to fly in a plane other than as a fare paying passenger on a commercial flight? *If yes, complete aviation questionnaire.*	□	□
14. Have you participated in skin or scuba diving, parasailing, motor sports/racing events or sky diving? *If yes, complete appropriate questionnaire.*	□	□
15. FEMALE APPLICANT ONLY: Are you currently pregnant? *If yes, state* **NUMBER OF WEEKS PREGNANT** *complete below:*	□	□
a. Is this your first pregnancy?	□	□
b. Have you experienced any health problems in past pregnancies?	□	□
c. Is your current pregnancy progressing without any health problems and no complications foreseen by your physician?	□	□

DECLARATION

I hereby agree for myself and any person who may have or claim any interest in said contract, as follows: (A) That every declaration hereinabove contained is true and I agree that such declarations shall with the following agreements, be taken as the basis of reinstatement of the contract, which lapsed for non-payment of premium. (B) That said contract shall not be reinstated by reason of any money paid or settlement made in payment of or on account of the premium for non-payment of which the said contract lapsed or any premium subsequent thereto, until the request shall be received and approved by the Company at the Head Office. (C) That the acceptance of this request and the reinstatement of the said contract shall not be taken as a precedent for future similar action on the part of the Company. (D) The terms and conditions of the incontestable, suicide, and other provisions in said policy shall apply to reinstatement thereof made upon this application, but the period of time specified in said provision shall run from the effective date of reinstatement. (E) It is hereby understood that the Company reserves the right to require further evidence of insurability.

Dated at: _____ this _____ day of _____ 20 _____.

Signature Insured: _____ Parent/Guardian (*If Insured is under age18 – and different from Owner)* _____

Signature Owner: _____ BAF Representative/Witness _____

FAILURE TO DISCLOSE INFORMATION OF ANY KIND MAY RESULT IN LOSS OF COVER.

Policy Number/s:	Client Name:

SECTION C – OTHER POLICIES

LIST ALL POLICIES WITH THIS COMPANY				
Policy #	**Date of Issue**	**Premium**	**Coverage Amount**	**ADB**
LIST ALL POLICIES WITH OTHER INSURANCE COMPANY/IES				
Name of Company	**Type of Insurance**	**Year Issued**	**Coverage Amount**	**ADB**

SECTION D – ADDITIONAL DETAILS *provide details to any YES answer given for Questions 1-15 of Section B*

Question No.:	Details (Include all dates, name of physician, reason for visit, treatment and overall results.)

DECLARATION & AUTHORIZATION

I hereby declare that my additional details are complete and true, and I agree that it will form part of my application to be considered for any reinstatement applied herein. I further agree that non-disclosure of any kind, may prevent reinstatement.

I hereby authorize any physician, hospital, clinic, insurance company or other institution/organization or person that has any record of my health to furnish information regarding me.

The original, together with certified copies of the same Reinstatement Application shall all be deemed an original.

Dated at: _____ this _____ day of _____ 20 _____.

Signature Insured: _____ Parent/Guardian (*If Insured is under age18 – and different from Owner)* _____

Signature Owner: _____ BAF Representative/Witness _____

FAILURE TO DISCLOSE INFORMATION OF ANY KIND MAY RESULT IN LOSS OF COVER.