East West Ageas Life Insurance Corporation
15th Floor One World Place, 32nd Street, Bonifacio Global City, 1634 Taguig City, Philippines Tel. +63 2 683 8766 | TIN: 009-156-012-000

Application for Reinstatement of Life Insurance

Instruction(s):
1. This form must be completed in its entirety and properly signed.
2. Each insured covered by the policy is to complete this form if the life insurance lapsed more than six (6) months ago.
3. Use and/or submit Amendment Form to reinstate a policy that lapsed within the past six (6) months.

Note: We may require further evidence of insurability to reinstate your policy.

Policy No.

General Information

Name of Life Insured

Title | Last name | First name

Middle name | Preferred name | Gender ○ Male ○ Female

Date of birth (M M D D Y Y Y Y) | Place of Birth | Nationality

SSS/GSIS number | TIN

Complete Address:

Unit no. | Floor | Building name | House/Building no. | Street name

P.O Box | Barangay/District | City/Municipality | Postcode

Name of Policy Owner

Title | Last name | First name

Middle name | Preferred name | Gender ○ Male ○ Female

Date of birth (M M D D Y Y Y Y) | Place of Birth | Nationality

SSS/GSIS number | TIN

Complete Address:

Unit no. | Floor | Building name | House/Building no. | Street name

P.O Box | Barangay/District | City/Municipality | Postcode

Evidence of Insurability

Please answer the following questions and provide details for all "Yes" answers in the Additional Information section on page 3. Complete details will allow us to evaluate your request for reinstatement without delay.

Since the issue date of the policy, has the	Insured		Owner	
	Yes	No	Yes	No
1. Consulted or been treated by any physician or other licensed medical practitioner?				
2. Had any physical impairment, sickness, operation, mental illness/disorder, physical injury?				
3. Taken or been advised to take any prescription or non-prescription medication? If yes, indicate the name of medication, dosage and prescribing physician.				
4. Had a changed in weight in the past 12 months? If yes, gain (lbs.) _____ loss (lbs.) _____ Reason: _____ Provide current height _____ and weight _____				
5. Been diagnosed or received treatment from a member of medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?				
6. Ever used cigarettes, cigars, or any other form of nicotine-based products? If yes, do you currently smoke or use other form of nicotine-based products? Yes/No _____ What product do you use and how frequent? _____ If not currently smoking or using a nicotine-based product, provide date last used: _____				
7. a. Used barbiturates, heroin, cocaine, marijuana, or any other illegal, restricted, or controlled substance except as prescribed by a physician, or been advised by a physician or other medical practitioner to seek or receive treatment for drug use? If yes, provide full and completed details. b. Been convicted for drug use, possession or distribution? If yes, provide full and completed details.				
8. a. Been advised by a physician or other licensed medical practitioner to limit or cease the use of alcoholic beverages? b. Been counseled, sought help or treatment, or been advised by a physician or other licensed medical practitioner to undergo counseling or treatment for alcohol problems? c. Attended or joined any organization for alcohol or related problems?				
9. Had an immediate family member (parent, brother, or sister) with heart disease, stroke, diabetes, cancer, polycystic kidney disease or other familial disease? If yes, identify relationship, disease, age at diagnosis, current age or age at death.				
10. Engaged or intend to engage in racing, mountain/rock climbing, scuba or sky diving? If yes, provide full and complete details.				
11. Flown in the last five (5) years or intend to fly other than as fare paying passenger on scheduled airlines? If yes, provide full and complete details.				
12. Intend to travel or reside outside the Philippines within the next five years? If yes, provide dates, location, purpose of travel, frequency, and intended length of stay.				
13. Applied to any other company for new insurance or reinstatement of lapsed coverage? If yes, provide type, company, amount and status, including reason if refused or rated.				
14. What is the total amount of life insurance currently in force (outside of Troo), excluding this policy?				

Additional Information (details regarding ***"yes"*** answers).	
Question No.	**Details**

- The Life Insured and any Payor/Owner hereby:
  - declare that the statements and answers contained on this Application for Reinstatement and any supplements thereto, are true to the best of their knowledge and belief and are made to induce the Company to reinstate the above numbered policy.
  - agree that the reinstatement of coverage applied for shall in no event become effective unless this application is approved by the Company and the full amount of premium due is paid while the insured is actually in the state of health and insurability represented in this Application for Reinstatement and any supplements thereto.
  - agree to notify the Company of any changes in statements or answers while the application for reinstatement is pending.
  - agree that this Application for Reinstatement and any supplements thereto, copies of which shall be attached to and made part of the policy.
- Troo is requested to reinstate the above-numbered policy. It is agreed that except from non-payment of premiums or any other grounds recognized by the law and jurisprudence, the Company cannot contest this policy after it has been in force during the lifetime of the insured for two (2) years from its date of last approved reinstatement. This incontestability period will not apply to any supplementary contracts relating to benefits payable in the event of total disability and benefits which grant additional insurance specifically against death by accidental means.

Signed at _____this _____day of _____20 _____

Printed name and signature of Life Insured

Printed name and signature of Policyowner

Printed name and signature of irrevocable beneficiary

Printed name and signature of Troo Advisor/Code