Declaration of Insurability Form
Disability Insurance Reinstatement

1. Personal Information

Full Name

Date of Birth

Home Address

Policy Number

2. Health Declaration

☐ I declare that my health condition has not changed since my last application.

If any changes or recent illnesses, please describe:

Current Physician Name (if any)

3. Disability Statement

Have you applied for, or are you receiving any disability benefits from another provider?

☐ Yes ☐ No

If Yes, please provide details:

4. Declaration & Authorization

I hereby declare that all statements provided in this form are true, complete, and correctly recorded to the best of my knowledge and belief. I understand that any false statements may lead to denial of reinstatement or claim.

I authorize any physician, hospital, clinic, or insurance company to disclose to the insurer any information regarding my health history for purposes of underwriting.

Signature of Insured

Date