Policyholder Reinstatement Request Form Disability Insurance

1. Policyholder Information

Full Name

Policy Number

Date of Birth

Phone Number

Email

Address

2. Policy Details

Plan Type

Date Policy Lapsed

Reason for Lapse

3. Declaration of Health

Please answer the following health-related questions since your policy lapsed:

☐ No changes in health or occupation ☐ Yes, details below

If yes, please explain:

☐ I have filed a claim for disability since lapse ☐ I have not filed any claim

Other Relevant Information

4. Payment of Outstanding Premiums

Please indicate your method of payment or attach payment with this form.

Payment Method

5. Acknowledgement & Signature

I hereby request reinstatement of my disability insurance policy. I declare that the above information is accurate and complete.

Policyholder Signature

Date

For Office Use Only

Received By

Approval Date

Remarks