

# Reinstatement Application Form (Lapsed Policy)

## 1. Policy Information

Policy Number

Plan Name

Policy Issue Date

## 2. Policyholder Information

Full Name

Date of Birth

Contact Number

Address

Email Address

Occupation

## 3. Reason for Policy Lapse

## 4. Declaration of Health Status

Please state any changes in your health status since the policy lapsed:

## 5. Additional Information

Other relevant information (if any):

## 6. Declaration & Authorisation

I hereby declare that the information provided above is true and complete to the best of my knowledge. I authorise the insurer to obtain any information required from other sources in connection with this application.

Signature of Policyholder

\_\_\_\_\_

Date

Signature of Witness

\_\_\_\_\_

Date

*Note: Submission of this application does not guarantee policy reinstatement. Subject to underwriting approval.*