Statement of Good Health

For Insurance Reinstatement

Name of Insured: _____

Policy Number: _____

Date of Birth: _____

Contact Number: _____

Address: _____

Please answer the following:

1. Have you been diagnosed with or treated for any illness, injury, or medical condition since the lapse of your policy? _____
2. Have you experienced symptoms requiring medical consultation, hospitalization, or prescribed medication during this period? _____
3. Are you currently in good health and free from any physical or mental impairment? _____

I hereby certify that I am in good health and that all statements made above are true and complete to the best of my knowledge. I understand that any false or incomplete information may result in denial of reinstatement or future claims.

_____

Signature of Insured

Date: _____