APPLICATION FOR REINSTATEMENT
CS 025

Agent: _____ **Agent No:** _____

Branch: _____

Please tick the appropriate box, where applicable.

[3]Name of Life Insured	Name of Insured Person (if other than Life Insured)	Client Number
Sum Assured **Basic $** **NLP $**	**Benefits** ☐ AD & D ☐ ASDI ☐ WOP/PWOP	**Date of Birth** **Age**
Mailing Address: **E-mail Address:**	[2]TRN (Life Insured) **TRN (Insured Person)** (if other than Life Insured)	**Tel. No.** **(W):** **(H):** **Cell.:**
Country of Birth:	**Country of Citizenship:**	**Nationality:**

APPLICATION FOR REINSTATEMENT OF [1] POLICY NO. _____

I hereby request that the captioned policy be reinstated and payments recommenced by way of ☐ **Redating** ☐ **Revival** in accordance with the company's normal procedures.

I understand that the Policy shall not be in full force unless and until the company has consented in writing to grant reinstatement, and I agree to accept the return of any payments made to the Company in connection with this application, should the Company decline to reinstate the policy.

I understand that by requesting the reinstatement of this policy, I am acknowledging that:

☐ The policy **lapsed** due to non-payment of premiums as required by the original contract and the risk on the Life Insured ceased, or

The policy was made **paid-up** according to the policy provisions, due to non-payment of premiums.

For the Guardian Assure policy only: (This provision may only be exercised once.)

☐ I wish to utilize 50% of funds from the Coverage Account.

I understand that I will bear the cost of all medical evidence required by the Company, and that on reinstatement by redating the premium and/or sum insured will be adjusted accordingly.

For the purpose of obtaining reinstatement I enclose the following:

☐ Cost to Reinstate $ ☐ Service Charge ☐ New Salary Deduction Authority (if applicable)

☐ New Pre-authorized Payment Advice (if applicable)

Signed at ..... this ..... day of ....
Place Day Month Year

....
Name & Signature of Witness Signature of Life Insured

....
Name & Signature of Witness Signature of Insured Person (If other than Life Insured)

N.B. i) Declaration of Health is to be completed unless this is a no-risk policy. Medical requirements are as per Underwriting Requirement Chart

[1]Policy No. _____ [2]Life Insured's TRN _____

[3]Name of Life Insured_____

POLICYHOLDER DATA:

Are you a permanent resident, citizen or national of another country? ☐ Yes ☐ No If yes, please state:_____

Are you a US citizen, resident or green card holder? ☐ Yes ☐ No

Taxpayer Identification Number (TIN) (if applicable): _____

Where do you pay taxes? _____ Do you pay taxes in any other jurisdiction? ☐ Yes ☐ No

If yes, please state: _____

Have you recently changed your residential or mailing address? ☐ Yes ☐ No

If yes, please state new address _____
(Please attach proof of address)

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) CERTIFICATION

☐ I certify that I the undersigned am NOT a citizen, national, resident, or green card holder of the United States. I further agree to advise Guardian Life Limited as soon as I become aware of any changes that would render this declaration invalid.

☐ I certify that I the undersigned am a citizen, national, resident or green card holder of the United States. I further confirm that the Taxpayer Identification Number (TIN) provided above is correct (or I am awaiting a number to be issued to me).

....
Signature of US / Non-US Customer Date

POLITICALLY EXPOSED PERSONS (PEP)/PUBLIC FIGURES:

Do you, any immediate family or close associates, currently serve or previously served in the capacity of an official/senior official in the administrative, legislative or executive division of the government, military or judiciary of your country of residence or in any other foreign country government? ☐ Yes ☐ No

Do you, any immediate family or close associates, currently serve or previously served in the capacity of assistant commissioner or higher of the police force or as a senior executive of a state owned company of your country of residence or a foreign government? ☐ Yes ☐ No

If you have ticked "Yes" to any of the above, please state the capacity? _____

AUTHORIZATION, DECLARATION AND CONSENT:

I understand that the information provided in this form will enable Guardian Life Limited to manage operations and risks and allow for the enhancement of customer experience. I further comprehend that the information provided may be used to appease information requests of the regulators or in order to satisfy legal or regulatory requirements. I confirm that the information provided is true and correct and can be relied upon by Guardian Life and hereby grant permission for the usage of the information for the purposes herein stated or as may be required from an operational standpoint.

....
Signature of Life Insured Signature of Insured Person (If other than Life Insured)

....
Date Date

[1]**POLICY NO. _____** [2]**TRN _____**

[3]**Name of Life Insured _____**

DECLARATION OF HEALTH

QUESTIONS APPLY TO LIFE ASSURED AND PROPOSER. FULL DETAILS TO BE GIVEN IN RESPECT OF ALL QUESTIONS ANSWERED "YES" **SINCE THE PROPOSAL FOR INSURANCE IN RESPECT OF POLICY NO. _____**	Tick relevant column			
	LIFE INSURED		INSURED PERSON	
	YES	NO	YES	NO
1. (a) Have you suffered any illness, accident, physical defects or consulted any doctors? (Give full details - date, type of illness, name of doctor) .... (b) Are you currently receiving any treatment or medication? (Give full details - type of medication taken and how often)	☐	☐	☐	☐
2. Have you been advised to have any operation, or is one now being contemplated? (Give full details - type of operation, name of doctor and hospital, etc.)	☐	☐	☐	☐
3. Has there been any change in your Family History? e.g. Death, Illness (Give full details)	☐	☐	☐	☐
4. Has any application on your life been rated, declined or postponed by this Company or any other Life Insurance Office? (Give full details)	☐	☐	☐	☐
5. Has there been any change in circumstances regarding your occupation, prospects of residence in another country, or are you taking part in flying other than as a fare-paying passenger on a scheduled airline? (Give full details) ..... (NOTE: For Aviation - complete Aviation Questionnaire)	☐	☐	☐	☐
6. Have you participated in hazardous sports such as Automobile and/or Motor cycle Racing (including Rally Driving), Skin- and/or Scuba-diving, Ballooning and/or Hang-gliding, Skydiving and/or Parachuting or any other hazardous sport e.g. karate or boxing? (Give full details) ..... (NOTE: Complete relevant questionnaire where applicable)	☐	☐	☐	☐
7. Have you ever used any narcotic drugs (e.g. crack/cocaine, marijuana/ganja) sedatives, tranquilizing or hallucinogenic drugs except as prescribed by a physician? **(If yes, complete Drug Usage Questionnaire)**	☐	☐	☐	☐
8. (a) Have you ever smoked? **(If yes, answer question 8b)** ..... (b) Have you smoked cigarettes, cigars, cigarillos or marijuana within the last 12 months? **If yes**, No. of years smoked_____Quantity smoked_____ per _____ **If no,** When did you last smoke? _____ For how long did you smoke? _____ Quantity Smoked _____ per _____ **(If yes to marijuana, complete Drug Usage Questionnaire)**	☐ ☐	☐ ☐	☐ ☐	☐ ☐

[1]**Policy No:**_____ [2]**TRN:** _____

[3]**Name of Life Insured:** _____

FULL DETAILS TO BE GIVEN IN RESPECT OF ALL QUESTIONS ANSWERED "YES"	Tick relevant column			
	LIFE INSURED		INSURED PERSON	
	YES	NO	YES	NO
9. (a) Have you ever been **treated for, counselled for or told you had**:- AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex), or any other Immunological Disorder? (If yes, give details)	☐	☐	☐	☐
(b) Have you ever been **tested for** Antibodies to the AIDS Virus (Human immunodeficiency virus, HIV and/or HTLV - 111)? (If yes, give details)	☐	☐	☐	☐
(c) Do you belong to any of the following high risk groups:- ☐ Homosexual Men ☐ Bisexual Men ☐ Intravenous Drug Users ☐ Haemophiliacs or other blood diseases requiring transfusion ☐ Sexually promiscuous (having contact with several partners, including prostitutes) ☐ Sexual partners of the preceding groups ☐ Babies born to AIDS infected mothers? (If yes, give details)	☐	☐	☐	☐
10. **FEMALES ONLY** (a) Are you now pregnant? (State how far advanced, also name and address of your doctor)	☐	☐	☐	☐
(b) Have you ever consulted a doctor concerning any dysfunction of the reproductive system? (Give full details - Type of dysfunction, date, name and address of doctor, etc.)	☐	☐	☐	☐

11. Life Insured's Height and Weight	Insured Person's Height and Weight
_____ft/cm _____lb/kg	_____ft/cm _____lb/kg

DECLARATION

I HEREBY DECLARE that my answers to the questions above are to the best of my knowledge and belief true and I agree that this declaration shall form part of the basis of the contract between myself and the Company under Policy No..... I further agree that if any fraudulent or untrue allegation be contained herein, all monies which shall have been paid on account of such Assurance, shall be forfeited to the Company, and that the Policy shall be void, and I further agree that the liability of the Company under the Policy shall recommence only on payment of all arrears of premiums which I owe under my said Policy, provided that my health remains meanwhile unaffected. I consent to the Company seeking medical information from any Doctor who at any time has attended me, or making inquiries of or from any office to which I have at any time made a proposal for Life or Health Assurance and I authorize the giving of such information.

Dated this .....day of ....……

ADDRESS .....……. SIGNATURE .....……
Life Insured

ADDRESS ..... SIGNATURE .....……
Insured Person (If other than Life Insured)

FOR HEAD OFFICE USE ONLY

[3]NAME:	AGE	[1]POLICY NO:	SUM ASSURED:
		[2]TRN	

ACTION TAKEN	DATE AND INITIALS
RECEIVED BY HEAD OFFICE ☐	
VERIFICATION OF ATTACHMENTS ☐	
CHECK DONE FOR IMPAIRMENT ☐	
CHECK DONE FOR HIV ☐ HIV LOCATED YES ☐ NO ☐	
MONEY TRANSFERRED FROM OUTSTANDING DISBURSEMENT ☐	
CHANGE EFFECTED ON SYSTEM ☐	
ENDORSEMENT DISPATCHED ☐	

IMPAIRMENT DETAILS

TYPE	COMPANY	YEAR	REASON CODES

NOTES TO CHIEF MEDICAL OFFICER

CMO'S REMARKS & ECG INTERPRETATION

MEDICAL DETAILS OF LIFE INSURED	MEDICAL DETAILS OF INSURED PERSON
DATE OF MEDICAL:	DATE OF MEDICAL:
HEIGHT: WEIGHT:	HEIGHT: WEIGHT:
PULSE: BP:	PULSE: BP:
FAMILY HISTORY:	FAMILY HISTORY:
OTHER FEATURES:	OTHER FEATURES:
PREVIOUS PAPERS	PREVIOUS PAPERS

UNDERWRITER'S DECISION	DATE	SIGNATURE

REASSURANCE

	RETENTION	REASSURANCE
LIFE AD & D WOP NEW LIFE PLUS		

Form# CS.E 0006/00025 5/2002 ; Revised 11/2003; 03/2010; 05/2013; 03/2016; 11/2019

Index by: Policy #, TRN, Name of Life Insured

(Please scan all pages)