

APPLICATION FOR REVIVAL of the GUARDIAN LIFESAVER CS 126



AGENT: _____ AGENT NO: _____

BRANCH: _____

³Name of Life Insured:	²TRN (Life Insured):	Client Number:	
Name of Insured Person (if other than Life Insured):	TRN(Insured Person, if other than Life Insured)	Date of Birth:	Age:
E-mail Address (Life Insured):	Telephone No.(s) (Life Insured):	Sum Assured:	

Mailing Address (for this policy):

APPLICATION FOR REVIVAL OF ¹POLICY NO. _____

I hereby request that the captioned policy be revived in accordance with the Company's normal procedure.

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

I acknowledge that the policy lapsed due to non-payment of premiums as required by the original contract and the risk on the Life Insured ceased.

For the purpose of revival, I enclose the following:

- Cost to Revive \$ _____ New Salary Deduction Authority (If applicable)
 Service Charge \$ _____ New Pre-authorized Payment Advice (If applicable)

QUESTIONS:

- ◆ Have you ever been diagnosed with or treated for any form of cancer, or been told that a condition you have or had may be cancerous? Yes No
 - ◆ Have you ever been diagnosed as being HIV positive? Yes No
 - ◆ Have you ever been treated for, counselled for or told that you have/had AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or any other immunological disorders? Yes No
- The questions below are to be answered if the Guardian Care Critical Illness Rider has been selected:**
- ◆ Have you ever been diagnosed with or treated for a heart condition? Yes No
 - ◆ Have you ever been diagnosed with or treated for a stroke? Yes No
 - ◆ Have you ever suffered major burns? Yes No

(If yes to any of the above questions, the policy will not be revived.)

DECLARATION:

I hereby declare that to the best of my knowledge, the answers given are complete, full and true and I understand that failure to disclose important and material information deliberately or otherwise will make this contract invalid and no benefits will be paid.

I understand that no claim can be made under this Policy for Cancer, HIV, Heart Attack, Stroke, AIDS or Major Burns diagnosed before this policy has been in force one hundred and eighty (180) days from the date of revival.

Signed at _____ this _____ day of _____

Place
Day
Month
Year

Witness' Name & Signature

Life Insured's Signature

Witness' Name & Signature

Insured Person's Signature (If other than Life Insured)