APPLICATION FOR REVIVAL of the GUARDIAN CARE PLAN
CS 100

AGENT: _____ AGENT NO.: _____

BRANCH: _____

[3]**Name of Life Insured**:	[2]**TRN (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 [1]POLICY 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 treated for or diagnosed with any form of Cancer, or been told that a condition you have or had may be cancerous?	☐ Yes	☐ No
Have you ever been treated for or diagnosed as being HIV positive?	☐ Yes	☐ No
Have you ever been treated for or diagnosed with a heart condition?	☐ Yes	☐ No
Have you ever been treated for or diagnosed with a stroke?	☐ Yes	☐ No
Have you ever been treated for, counselled for, or told you have AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorders?	☐ 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 and the statements made are complete, full and true and I understand that failure to disclose any important 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, Stroke, Major Burns or Heart Attack diagnosed before the 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 Life Insured

…… ……
Witness Insured Person (If other than Life Insured)

Form# CS.E 0024/00100 9/04; 03/10

For Official Use Only: Index by: Policy #, TRN, Name of Life Insured