



APPLICATION FOR REINSTATEMENT OF LAPSED MEDICAL POLICY

Pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this application form fully and faithfully all the facts which you know or ought to know, otherwise nothing may be payable under the Policy.

Policy Number : _____
Name of Insured (Policyholder) : _____
Name of Insured Person(s) : _____
Payment of Outstanding Premiums : \$ _____ Cheque Number : _____

I wish to apply for reinstatement of the above Policy and confirm that the declaration below is true to the best of my knowledge and no material facts have been withheld:-

Health Declaration *(Not applicable for Insured Person(s) under Moratorium Underwriting terms)*

I / We* hereby declare that since the commencement of the above policy -

1. There has been no change in my / our* health or occupation status; and
2. I / We* have not had or have any intention to undergo any medical procedure or surgery, any medical test investigation (excluding yearly voluntary health screening) carried out on the recommendation of a doctor; and
3. I / We* have not sought any medical advice or treatment and are not intending to seek medical advice or treatment in the foreseeable future for any medical condition, disability/deformity/defect, symptom or injury.

If you or your Dependant(s)/Insured Person(s)(if applicable) cannot declare the statements as spelt out above, please provide your reason(s) below, noting the declaration number.

*Delete where applicable

Aviva Ltd reserves the right to call for any medical evidence necessary for proof of good health.

I understand that the Policy will be reinstated and the insurance cover restored only when an official letter confirming reinstatement has been issued by Aviva Ltd. Aviva Ltd will not be liable for any claims arising between the date of lapsing of the Policy and the reinstatement date of the Policy. In addition, treatment provided to the Insured Person within 30 days of the reinstatement date will also not be covered unless the treatment received as an Inpatient is for injuries caused by an accident occurring after the reinstatement date.

I further declare I am not an un-discharged bankrupt(s) and that I have committed no act of bankruptcy within the last 12 months and no receiving order or adjudication order in bankruptcy has been made against me during that period.

If a material fact is not disclosed in this application, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the licensed Financial Adviser representative but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Date Signature of Insured (Policyholder) Signature of Insured Person(s) Signature of Insured Person(s)

Note

If the Insured Person(s) is 16 years old and above, both the Insured and the Insured Person(s) are to sign this application.