TOKIO MARINE
INSURANCE GROUP

Policy No. _____

REINSTATEMENT APPLICATION FORM

IMPORTANT NOTICE:
You are to disclose in this application form, fully and faithfully all the facts, which you know or ought to know, otherwise the reinstatement of this policy may be null and void.

PARTICULARS		
	LIFE ASSURED	POLICY OWNER (IF DIFFERENT FROM LIFE ASSURED)
Full Name as per NRIC / Passport		

PART 1 : HEALTH DECLARATIONS Note: Please complete Reinstatement Application Form.		
Please answer ALL the questions below:	**Life Assured**	**Policy Owner**
1. Do you smoke or have you smoked in the last 12 months?	☐ Yes ☐ No If yes, please confirm average daily consumption: _____ cigarettes/cigar.	☐ Yes ☐ No If yes, please confirm average daily consumption: _____ cigarettes/cigar.
2. Do you consume beer, wine or other alcohol?	☐ Yes ☐ No If yes, please state: Average consumption weekly: _____glasses Type of alcoholic drinks: _____	☐ Yes ☐ No If yes, please state: Average consumption weekly: _____glasses Type of alcoholic drinks: _____
3. Do you engage or have any intention of taking up any other hazardous business, occupation or sports?	☐ Yes ☐ No If yes, please describe type of pursuit :	☐ Yes ☐ No If yes, please describe type of pursuit :
4. Has any of your proposal, reinstatement, or application for renewal ever been declined, postponed, rated, restricted or in any way modified?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
5. (a) What is your current country of residence? (b) Do you intend to reside outside of your current country of residence for more than 1 month?	..... ☐ Yes ☐ No Details of YES answer:	..... ☐ Yes ☐ No Details of YES answer:

RECEIVED DATE RECEIVED DATE	*For Office Use:*

Tokio Marine Life Insurance Malaysia Bhd.
[199801001430 (457556-X)]
Ground Floor, Menara Tokio Marine Life,
189, Jalan Tun Razak, 50400 Kuala Lumpur.
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Fax : (603) 2162 8068
Customer Care Hotline : (603) 2603 3999
Website : tokiomarine.com

A member of the
Tokio Marine Group

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PART 1 : HEALTH DECLARATIONS (CONTINUE)		
6. Have you ever injected or used illegal or addictive drugs or narcotics?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
7. Do you intend to enter into the Navy, Aviation or Military Service?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
8. Have you ever had, or told to have or been treated for :-		
(a) Epilepsy, stroke, mental disorder, any other disorder of the brain or central nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Bronchitis, asthma, tuberculosis, any other disorder of the lungs or respiratory system?	☐ Yes ☐ No	☐ Yes ☐ No
(c) High blood pressure, raised cholesterol, chest pain, anaemia, or any diseases of heart, blood, blood vessels or other circulatory system?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Arthritis, rheumatic fever, gout, thyroid disorder or any other disorder of the muscle, bones, joints, spine or glands?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Hepatitis B/C, Jaundice, diabetes, diseases of liver, gall-bladder, stomach or intestines, any other disorder of the digestive system?	☐ Yes ☐ No	☐ Yes ☐ No
(f) Albumin, blood, pus or sugar in urine, renal stone, any other disorder of the kidney or the genito-urinary system?	☐ Yes ☐ No	☐ Yes ☐ No
(g) Ear-ache, ear-discharge, any other disorder of the ear, eye, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
(h) Gonorrhoea, syphilis, stricture, genital herpes or any other venereal disease?	☐ Yes ☐ No	☐ Yes ☐ No
(i) Cancer, tumour, cyst, polyp, growth of any kind, abnormal skin lesion or rashes, enlargement of lymph node and any other form of skin disorder?	☐ Yes ☐ No	☐ Yes ☐ No

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PART 1 : HEALTH DECLARATIONS (CONTINUE)		
8. (j) Have you or your spouse ever been medically advised, counselled or treated in connection with AIDS or an AIDS related condition or infection with any HUMAN IMMUNODEFICIENCY VIRUS (HIV)? If you have answered any question 8 above as "Yes", please provide details.	☐ Yes ☐ No	☐ Yes ☐ No
9. In the PAST 5 YEARS, have you had any:- (a) Medical advice, hospital treatment or long term care treatment /medication? (b) Operation done and /or advised for or planned surgery? (c) Physical examination or screening test done such as X-ray, ECG, biopsy, MRI or CT scan, CT Angiography or blood study. If you have answered any question 9 above as "Yes", please provide details.	(a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No	(a) ☐ Yes ☐ No (b) ☐ Yes ☐ No (c) ☐ Yes ☐ No
10. Have you ever had a parent and /or siblings who was diagnosed with any of these conditions before aged 60 i.e. a) Hereditary disease b) Kidney disease c) Diabetes d) Heart disease e) Stroke f) Cancer	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:

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PART 1 : HEALTH DECLARATIONS (CONTINUE)		
11. **FOR FEMALE APPLICANTS ONLY**		
(a) Are you pregnant?	☐ Yes ☐ No If yes, please confirm months of pregnancy: ____ months.	☐ Yes ☐ No If yes, please confirm months of pregnancy: ____ months.
(b) Do you have any female reproductive system disorder such as excessive menstrual bleeding, uterine fibroid, ovarian cyst, cervicitis, abnormal PAP smear?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
(c) Do you have any breast disorder such as breast cyst, lump, abscess and inflammation?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
(d) Do you have any complications at child birth such as difficult labour, miscarriage or caesarean?	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:
12. Do you have any other disease, disorder or severe injury not mentioned above, or other than already disclosed have you had or have symptoms for which you: a) intend to seek medical advice b) are awaiting treatment c) are awaiting results of tests or investigation	☐ Yes ☐ No Details of YES answer:	☐ Yes ☐ No Details of YES answer:

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PART 2 : DECLARATION

I. I/We, the Policy owner/ Life Assured under the Policy, hereby apply for a reinstatement of the Policy.

II. I/We declare that the information given in this application together with any other document relating to this application is true, full and complete and I/we have not withheld any information.

III. I/We acknowledge that the Policy shall not be considered as having been reinstated until this reinstatement application has been unconditionally accepted by you during my/our lifetime and until all your other requirements for reinstatement have been fully satisfied.

IV. I/We acknowledge that the reinstatement of the Policy is at your sole discretion and in consideration of you agreeing to consider my/our application, and as a basis for you accepting my/our application, I/We hereby agree that any reinstatement of the Policy shall be voidable at your sole discretion if:

i) at any time hereafter it is discovered that any of the answers to the questions asked or any declarations in this application is found to be untrue in any way; or

ii) death by suicide of the Policy Owner/Life Assured (as the case may be) under the Policy, whether while sane or insane, occurs within twelve (12) months of the date on which you approve the reinstatement of the Policy.

Signed at _____ *(place)* on _____ *(date)*

Signature of Life Assured	Signature of Policy Owner (if the Life Assured is of age 10 and above but below age 16)	*Signature of Witness
Name :_____	Name :_____	Name :_____
NRIC No.:_____	NRIC No.:_____	NRIC No.:_____
Tel. No. :_____	Tel. No. :_____	Tel. No. :_____

***STATEMENT OF WITNESSS :**

1. I hereby witness and certify that the signature(s) in this form was/were made before me and that to the best of my knowledge it is/are the signature(s) of the Policy Owner/Life Assured under the Policy.
2. The Witness must be at least 18 years of age and of sound mind.

Note: A copy of NRIC/Passport/Birth Certificate of the Policy Owner/Life Assured is submitted for verification by the Company.

PART 3 : DATA PRIVACY

I/We understand and agree that the information I/we supply will be collected, used and processed by the Company, its agents and its authorised parties (within or outside of Malaysia) for the purposes of processing this application and to facilitate the Company's function as an insurance company. I/We understand that I/We have a right to obtain access to and to request correction of my/our personal information held by the Company by contacting the Company's Customer Service Representatives.

Signed at _____ *(place)* on _____ *(date)*

_____
Signature of Policy Owner
Name:
NRIC No.:

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