Manulife Financial

APPLICATION FOR CHANGE TO REINSTATE HEALTH AND DENTAL COVERAGE

AFFINITY MARKETS NEW BUSINESS AND UNDERWRITING

Name of Applicant (Policy Holder):

Name of Co-Applicant (Co-Policy Holder), if any:

Dependants Under the Policy:

Terminated Policy No.: 1777 -

Policy Termination Date:

INSTRUCTIONS: PLEASE READ CAREFULLY AND COMPLETE. APPLICANT AND CO-APPLICANT, IF ANY, MUST SIGN THIS FORM

In this document, "I/we" and "my/our" means the policy holder and co-policy holder who was/were insured under the above referenced policy number.

In consideration of my/our application for reinstatement of coverage, since the policy termination date of my/our coverage with the Manufacturer's Life Insurance Company, I/we declare that all individuals who were insured on the termination date of the policy:

	AGREE	DISAGREE
Have not suffered any illness or injury	☐	☐
Have not consulted and/or are not scheduled to consult with any medical practitioner for any reason	☐	☐
Have not had any detrimental change to my/our health	☐	☐
Have not had any tests done, nor do I/we have any tests pending, nor have I/we been advised to have any tests done	☐	☐
Am/are not waiting for any test results	☐	☐
Have not incurred any claims and/or are not aware of any claims that will be incurred	☐	☐

I/we declare that the above statements are true and complete to the best of my/our knowledge and belief, and acknowledge that if I/we disagree with any of the above statements, that full details must be provided below, including the individual(s) to whom the answer applies, and the nature of the condition, cause, treatment, any hospital dates, duration, results and the name and addresses of doctor or other practitioners below.

I/we acknowledge that Manulife Financial may require additional information to assess my/our request for reinstatement of coverage.

I/we also acknowledge that if the policy is reinstated, all terms and conditions of the policy will continue in effect as they were prior to the reinstatement date, except that the two-year incontestability period will begin again on the effective date of reinstatement with respect to any information provided in this application, and that all retroactive and current premium payments since the policy termination date must be paid in full in order to reinstate my/our policy.

Signature of Applicant /Insured _____ Date (dd/mm/yy) _____

Signature of Co-Applicant /Insured _____ Date (dd/mm/yy) _____