AYALA LIFE
ASSURANCE INCORPORATED

Ayala Life-FGU Center, 6811 Ayala Avenue, 1226 Makati City * Tel.: 888-5433

APPLICATION FOR REINSTATEMENT
ORDINARY LIFE

I (We), _____, hereby apply for reinstatement of my Policy No. _____ which under its terms is now lapsed. As basis for such reinstatement, I make the following Medical Declaration:

MEDICAL DECLARATION		Insured	Payor
	Indicate your date of birth, height and weight in the proper boxes on the right side. BIRTH DATE / HT. / WT.		
	Answer all questions below with either ñYESò or ñNOò		
	Will you submit to a Medical Examination if so required by the company?		
	1. Have you now or ever had disease of the a. Brain or Nervous System:é like fainting spells, paralysis or other diseases thereof?		
	b. Eye, ear , nose & throat, like blindness, discharge/blood from the ears or nose, pyorrnea, tonsilitis or other diseases thereof?		
	c. Heart or lungs, like chest pain, high blood pressure, shortness of breath, asthma, chronic cough, tuberculosis, spitting of blood or other diseases thereof?		
	d. Stomach or liver, like ulcer, appendicitis, chronic indigestion, inflammation of liver and gall bladder, jaundice (yellowish discoloration of skin) or other diseases thereof?		
	e. Kidneys and urinary bladder, like frequent urination, kidney ureteral stones, abnormalities in the urine or other diseases thereof?		
	f. Blood and blood forming organs, like anemia, spleen enlargement, leukemia or other diseases thereof?		
	2. Have you lived with or been closely associated with anyone suffering from tuberculosis since your last Medical Declaration?		
	3. Have you now or ever had any other illness, disease, injury, or impairment in any part of the body not mentioned herein? If so, what?		
	4. Have you ever had or undergone operation, hospitalization, or consultation with or treatment by a physician since your last Medical Declaration?		
	5. FOR WOMEN ONLY. Married or Single age 18 years or over. Are you pregnant? é é é é é é é .. Monthsé é é é é é é . Have you ever had any abnormal pregnancies, abortions, miscarriages, or irregularity or delay of menstruation?		
	6. Have you changed occupation since your last Medical Declaration?		

EXPLAIN FULLY ANY "YES" ANSWER TO QUESTIONS

Question Number	Date of Onset Month Year	Duration	Description of Illness, Disease, Injury, Impairment, Operation, or Check Up	Name and Address of Doctors or Hospitals

New Occupation (State nature of work and specify duties)	Date Begun	Company or Office	Nature of Business

I (We), hereby represent that each of the foregoing answer is true and correct.

I (We) agree that said Policy shall not be considered reinstated until this application is approved by the Company at its Home Office during my lifetime and good health and until other Company requirements for the reinstatement of said Policy are fully satisfied.

I (We) further agree that any payment made or to be made in connection with this application shall be considered as deposit only and shall not bind the Company until this application is finally approved by the Company during my lifetime and good health. If this application is disapproved, I (We), also agree to accept the refund of all payment/s made in connection herewith, without interest, and to surrender the receipt of such payment/s.

Done at _____ on _____.

NOTE:
The Company may, at its discretion, reject this application or request the applicant to furnish additional evidence of insurability.

Printed Name & Signature of Payor	Right Thumbmark	Printed Name & Signature Of Insured	Right Thumbmark
Relationship to Insured			

I hereby certify that I collected P _____
As deposit for application for reinstatement per APR/OR No. _____ dated_____
the Paid-to-date of above as reported lapsed is _____
The applicant signed this in my presence.

_____ Agent Printed Name & Signature

_____ Code No.

Verified : _____ CSA Printed Name & Signature

_____ DATE

Complete Mailing Address:

_____ No./ St. Name

_____ Pob./Bo./Mun./Dist.

_____ Province / City

POSTAL CODE

Tel. No. _____

FOR HO/BDO USE

		PARTICULARS	
Paid-to-Date	Premium	1. POLICY NUMBER	
Face Amount	Charges	2. NAME OF INSURED	
No. of Years Paid	ODI	3. OFFICIAL RECEIPT NO.	
Date Reported	Total	4. AMOUNT OF DEPOSIT	

APPROVED BY: _____ PRINTED NAME _____ SIGNATURE _____ BDO/SO NAME

DATE: _____

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