



RE F000101

## POLICY REINSTATEMENT FORM

FOR OFFICE USE ONLY

Received Stamp

Received by \_\_\_\_\_

Signature \_\_\_\_\_

Date and Time of Receipt \_\_\_\_\_

**Policy No.:**

**OR**

**Application No.:**

### REQUEST FOR REINSTATEMENT OF POLICY

I (Policyholder) request you to reinstate my above mentioned Policy which has lapsed. I confirm having made the payment of an amount of Rs. \_\_\_\_\_ (please mention Cheque / DD details through which payment is made) \_\_\_\_\_

**Please complete the questions below for the "Life Assured" by ticking the appropriate box (If your policy has premium funding benefit/waiver of premium option, a separate Reinstatement form needs to be filled)**

1. Has there been any change in your occupation between the date of the proposal and this declaration?  Yes  No
2. Has there been any change in your residential status between the date of proposal and this declaration?  Yes  No
3. Has any proposal/request for reinstatement of lapsed Policy on your life ever been postponed, declined, withdrawn or accepted at extra premium after the date of original proposal by Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited or any other Life Insurance Company?  Yes  No

\* Proposal means the application made for issuing this Policy.

In case "Yes" is marked against any of the questions above please attach additional sheet (if necessary) to give details.

### HEALTH DECLARATION FORM

1. Has there been any change in the status of your health between the date of the original proposal and this declaration?  Yes  No
2. Have you consulted any doctor for surgical operation or have been hospitalized for any disorder or been advised to undergo any medical investigation/treatment / consultation / or have any recurrent medical condition /symptoms for any medical condition other than minor cough, cold or flu?  Yes  No
3. Have you ever been investigated/treated or diagnosed with any of the following conditions.
 

Hypertension/High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain/Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other heart disease/problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV infection/AIDS or positive test to HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes/High blood sugar/sugar in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous, Psychiatric or mental disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke/Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis, or any other Lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver problems/Jaundice/Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems or disease of reproductive organs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer/Tumor or growth, Cyst of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood disorder (Such as Haemophilia, Thalassemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you suffered from any accident or injury from the date of lapse till the date of this application for reinstatement?  Yes  No
5. If responses to any of the questions for 1 to 4 above are yes, please provide details below or attach a separate sheet (if necessary) in the same format which should be duly signed.

Date of event/diagnosis	Diagnosis	Investigations done	Treatment details	Name, address & contact number of the doctor/hospital	Current status (including current medication)

6. Please attach copies of reports/discharge summary as mentioned in 5.
7. Have you been away from work for a continuous period of more than 7 days due to health reasons from the date of lapse till the date of this application? If yes, please provide details  Yes  No
8. Are you pregnant now? (Applicable for females only)  Yes  No  
 If yes duration in weeks \_\_\_\_\_

## POLICY REINSTATEMENT FORM

I/We hereby apply for reinstatement of the above mentioned Policy, which under its terms is now lapsed, and as a basis for such revival, I/We declare that I/We have answered the questions in this Policy Reinstatement form after fully understanding the nature of the questions and the importance of disclosing all information while answering such questions. I/We further declare that the answers given by me /us to all the questions in this form are true and complete in every respect and that I/We have not withheld any material information or suppressed any fact.

I/We further declare that this Policy Reinstatement form will also be the basis of the contract of insurance and if any untrue statement is contained in this form, the Company shall have the right to vary the benefits which may be payable and further if there has been a non-disclosure of a material fact the Policy may be treated as void and all premiums paid under the Policy may be forfeited to the Company.

If the Life Assured commits suicide for any reason, within one year from reinstatement of the Policy, no Benefits shall be payable under this Policy, other than the Fund Value as at the date of notification of death.

In order to enable the Company to assess the risk under my lapsed policy and any time thereafter, I hereby authorize my past and present employer(s) doctor/ hospital/ any Life and Non Life Insurance Company/ or organization or Life Insurance Association's medical register to release to the Company and the Company to release to any medical source/ any life and non life insurance company/ or Life Insurance Association's medical register or Government authorities, such details and provide such records of my employment/ business or other details as may be required/considered relevant. I give my consent to the Company or its agents to undertake the medical tests necessary for assessing my lapsed policy for reinstatement. I understand this may involve blood tests including HIV antibodies. I declare that in the event of being medically examined by the Company the answers given to the medical examiner authorized by the Company and in the questionnaires provided by the Company will be deemed to be part of the statements and answers given in this reinstatement application.

I/We understand that my/our Policy will not be considered to be reinstated until the Company's written acceptance of this application is received.

Please note that Policy Reinstatement form should be signed by both Life Assured and Policy Holder.

\_\_\_\_\_  
Name of Life Assured

\_\_\_\_\_  
Signature/Thumb Impression of Life Assured

\_\_\_\_\_  
Name of Policy Holder / Assignee  
(Assignee details required if Policy is assigned)

\_\_\_\_\_  
Signature/Thumb Impression of  
Policy Holder / Assignee

Date:   /   /      
(Mandatory)

Place: \_\_\_\_\_  
(Mandatory)

### Declaration, if this Form is signed in Vernacular/Thumb Impression above

I \_\_\_\_\_ Son/Daughter of \_\_\_\_\_, am an adult and residing at \_\_\_\_\_ (complete address to be provided) do hereby declare on solemn affirmation as under: I have read out and fully explained the contents of the Reinstatement form and all other documents incidental to revive the Insurance Policy from Canara HSBC Oriental Bank of Commerce Life Insurance Company Limited to Mr. / Mrs./Ms. \_\_\_\_\_ and he/she has understood the significance of the form. I have truthfully and correctly recorded the replies given by the Policy Holder/Life Assured and that the Policy Holder/Life Assured has affixed the signature/thumb impression above after fully understanding the contents thereof.

Solemnly affirmed at \_\_\_\_\_

On this   /   /

\_\_\_\_\_  
Declarant Signature

#### Instructions:

- The form should be completely filled in all aspects for us to consider your request for Reinstatement.
- Processing of the requests will be initiated on receipt of this form at any of our Company's Office. Upon receipt of this form at our Company's Office the acknowledgement slip will be sent to you. Please retain the acknowledgement Slip for future reference.
- The Company reserves the right to take appropriate decision and Policy may be Revived at Revised terms and conditions or declined or postponed as per the Company guidelines.
- Apart from this application form, if required, life assured has to undergo some medical tests at his/her own cost at Diagnostic Centre specified by the Company. The cost of such medicals will not be refunded by the Company irrespective of the Company's decision on the application for reinstatement.
- If the Policy is a Unit Linked Plan, units will be purchased as per the existing fund allocation. The effective date for NAV would be the date of receipt of all pending premium along with Interest (if any) or underwriting decision on the Reinstatement application whichever is later.