PhilPlans
Think Ahead!

12th/F STI Holdings Center
6764 Ayala Avenue
1226 Makati City

APPLICATION FOR REINSTATEMENT OF PLAN CONTRACT

INSTRUCTIONS and REMINDERS:

1. Requirements:
   - ☐ Fully accomplished APPLICATION FOR REINSTATEMENT OF PLAN AGREEMENT (Use one (1) form per plan)
   - ☐ Photocopy of 2 Valid IDs (Originals to be presented)
   - ☐ Reinstatement and Processing Fee (Non-Refundable)
2. This accomplished reinstatement form is valid for three (3) months from the date of application that was indicated in this form.
3. PhilPlans may, at its discretion, decline this application or request the Applicant to furnish additional evidence of insurability.

PLANHOLDER	NATIONALITY:	BIRTH DATE (MM/DD/YYYY)	DATE OF APPLICATION
PLAN NUMBER	**PLAN TYPE :**		**PRE-NEED PRICE**
EMAIL ADDRESS:	**LANDLINE NO:** **AREA CODE ( )**		**MOBILE NO:**

I hereby apply for reinstatement of my Pre-Need Plan with details above by the method I have checked below:

☐ **UPDATING.** Payment of all installments in arrears with surcharge of 15% per annum.

☐ **REDATING.** Payment of one installment. *For Education plans, a corresponding adjustment fee and installment amount may be required.*

I have paid, in connection with this application for Reinstatement the amount of _____ under OR No. _____ on _____.

I agree to the following terms and conditions of reinstatement:

1. The Plan Agreement shall not be considered reinstated until this application is approved by PhilPlans at its Head Office during my lifetime and good health and until all other company requirements for the reinstatement are fully satisfied.
2. Prior to the approval of this Application, any payment made or to be made shall be considered as deposit only and that my subsequent installments pending the approval of this application for reinstatement shall be promptly and regularly paid as scheduled without the need for any notice or demand from the Company.
2. For reinstatement by Redating, the maturity or availment date of the Pension or Education benefits shall be moved to a later date.
4. I agree to reflect the contact details – email address and contact number specified above - in my Plan Master Record with PhilPlans.

I further agree that reinstatement of my insurance coverage is subject to the following conditions:

1. HEALTH DECLARATION: I hereby represent and declare to the best of my knowledge that:
   a. I am not below 18 years old or more than 65 years and 6 months old.
   b. I have not been confined in any hospital, sanitarium or infirmary, nor received medical or surgical treatment for heart condition, high blood pressure, cancer, diabetes, lung, kidney, or stomach disorder or any physical impairment since the date of issuance of my plan agreement or since its last reinstatement.
   c. I am now in good health and able to perform the normal activities in pursuit of a livelihood and free from any physical or mental infirmity.

   EXCEPTIONS: _____

   I agree that if no exception is listed in the blank space provided for exceptions, it shall have the same effect as if the word "NONE" was written therein.
2. That it is understood and agreed that the required age for the application for insurance coverage is 18 years old and up to the maximum allowable insurable age per Insurance Benefit as provided in the General Provisions.
3. That it is understood and agreed that the reinstatement of my insurance is based exclusively upon the statements and representations mentioned upon the express condition that if there be any fraud, concealment, misrepresentation in the statement or representation of material risk, PhilPlans or its insurance provider, upon discovery thereof, shall have the right to declare such reinstatement of insurance coverage null and void.
4. That I hereby authorize any physician, hospital, clinic, insurance company, institution or person or other organization, such as the Medical Impairment Bureau, that has any record of me or my health to furnish PhilPlans or its insurance provider any and all information about my health and medical history and any hospitalization, medical advice , diagnosis, treatment of disease or ailment. I also consent to further investigation, if necessary. A photocopy of this authorization shall be valid as the original and may be provided by PhilPlans for purposes of the above.
5. That, if I am still insurable, the corresponding insurance coverage of my plan shall likewise be reinstated subject anew to a 1-year contestability period from the approval date of this reinstatement.
6. That I agree that if I am no longer insurable and when applicable to my plan type, I hereby authorize the Company to reinstate my plan without insurance coverage.

Done at _____ on _____, 20_____

1. _____
(Planholder's Signature Over Printed Name)

2. _____
(Planholder's Signature Over Printed Name)

WITNESS:

_____
Reinstating Sales Counselor's Signature Over Printed Name

SALES COUNSELOR'S CODE:	AGENCY/REGION NAME

FOR CHECK PAYMENTS: (To be filled-out by BSS)		**FOR HEAD OFFICE REMARKS:**
CHECK BANK NAME/BRANCH:	DATE DEPOSITED:	DUE DATE:
CHECK NO. :	DEPOSITORY BANK:	PLAN STATUS:
CHECK AMOUNT:	DEPOSITORY BANK ACCOUNT NO.	

Ch 5.19.2015