12/F STI Holdings Center
6764 Ayala Avenue1226
Makati City

APPLICATION FOR REINSTATEMENT OF PLAN CONTRACT
FOR GROUP BUSINESS

INSTRUCTIONS and REMINDERS:

1. Requirements:
   - ☐ Fully accomplished APPLICATION FOR REINSTATEMENT OF PLAN AGREEMENT
   - ☐ List of plans to be reinstated
   - ☐ Photocopy of 1 Valid ID of Authorized Signatory (Originals to be presented)
   - ☐ Reinstatement cost and Processing Fee (Processing fee is Non-Refundable)
2. This accomplished reinstatement form is valid for three (3) months from the date indicated in this of application form.
3. PhilPlans may, at its discretion, decline this application or request the Applicant to furnish additional evidence of insurability.
4. Submit Planholder Contact Information Form (PCIF) if there are changes in address, phone numbers or e-mail address.

GROUP / FRANCHISE NO.	**COMPANY/GROUP NAME** (Please print)	
MOBILE NO.	**EMAIL ADDRESS**	**TELEPHONE NO.**

We hereby apply for reinstatement of the Pre-Need Plan with details in the attached list by the method 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*.

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

We 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 First, Inc. ("PhilPlans") at its Head Office during the 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 the 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 PhilPlans.
3. For reinstatement by Redating, the maturity or availment date of our Pension or Education benefits shall be moved to a later date.

We further agree that reinstatement of the insurance coverage, if the same is included in this plan, is subject to the following conditions:

1. **HEALTH DECLARATION**: We hereby represent and declare to the best of our knowledge that:
   a. The covered participant 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 the plan agreement or since its last reinstatement.
   b. The covered participant is 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/We 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 of the Group Insurance Contract.
3. That it is understood and agreed that the reinstatement of the 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/we hereby authorize any physician, hospital, clinic, insurance company, institution or person or other organization, such as the Medical Information Database, that has any record of the participant or the participant's health to furnish PhilPlans or its insurance provider any and all information about the participant's health and medical history and any hospitalization, medical advice , diagnosis, treatment of disease or ailment in connection with the requirements of the participant's Plan Contract with PhilPlans, for which we 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 the covered participant is still insurable, the corresponding insurance coverage of the plan shall likewise be reinstated subject anew to a 1-year contestability period from the approval date of this reinstatement.
6. That, if the covered participant is no longer insurable and when applicable to the plan type, we hereby authorize PhilPlans to reinstate the plan without insurance coverage.
7. I/We hereby agree that this application for Reinstatement of Plan Contract shall be effective only upon the approval of PhilPlans First, Inc. ("PhilPlans").

My/Our signature indicates that I/we have reviewed and certified the correctness of all information stated in this form.

I/We hereby consent, without need of prior notification, to the processing, storage, and disclosure by the Company of all such personal and/or sensitive personal information in this form for the enforcement of my plan contract, and for all purposes deemed fit by the Company, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk management, underwriting and administration of insurance coverage and claims, data analytics and data sharing with the Company. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured. PhilPlans shall retain the information for the duration of your contract/business with it and for a reasonable time thereafter to comply with its legal obligations.

I/We understand that as the owner of my data, I may contact the Company at any time during normal business hours and exercise the following rights, among others: (a) to be informed of the type and extent of data in the Company's possession; (b) to have my data disposed of or deleted, subject to the legitimate need of the Company in order to fulfill its contractual obligations to me; (c) to correct or update my data as needed; and (d) to receive a copy of the data within a reasonable time upon request.

I/We agree that the company may store the said data for the duration of the contract and a reasonable time thereafter.

I/We understand that we may contact the Data Protection Officer of the Company for any concerns involving my data or privacy rights.

I/We hereby certify that I/we have fully read and understood the benefits and features of this plan and agree to be bound by the provisions of the plan contract.

Dated this _____ day of_____ year_____ at _____, Philippines.

WITNESS:

_____
REINSTATING SALES COUNSELOR (SIGNATURE OVER PRINTED NAME)

_____
SC CODE/AGENCY/REGION NAME

1. _____
SIGNATURE OVER PRINTED NAME OF AUTHORIZED SIGNATORY

2. _____
SIGNATURE OVER PRINTED NAME OF AUTHORIZED SIGNATORY

FOR CHECK PAYMENTS (To be filled-out by Cashier)		**FOR HEAD OFFICE USE**
CHECK NUMBER	DATE AND TIME DEPOSIT OR PICK-UP WAS MADE	DUE DATE:
BANK NAME AND BRANCH OF CHECK	DEPOSITORY BANK	PLAN STATUS:
AMOUNT OF CHECK	DEPOSITORY BANK ACCOUNT NO.	