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

APPLICATION FOR REINSTATEMENT OF PLAN CONTRACT

FOR INDIVIDUAL and SALARY ALLOTMENT

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 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 applicationform.
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.

PLAN NUMBER	**PLANHOLDER'S NAME** (Please print)		**NATIONALITY**
PLAN TYPE	**PHONE NUMBER**(Please include AREA CODE) ( )	**MOBILE NUMBER**	**EMAIL ADDRESS**

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 First, Inc. ("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 PhilPlans.
3. For reinstatement by Redating, the maturity or availment date of my Pension or Education benefits shall be moved to a later date.

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 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.
   b. 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 of the Group Insurance Contract.
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 Information Database, 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 in connection with the requirements of my Plan Contract with PhilPlans, for which 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, if I am no longer insurable and when applicable to my plan type, I hereby authorize PhilPlans to reinstate my plan without insurance coverage.

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

I hereby consent, without need of prior notification, to the manual or automated processing, storage and disclosure by PhilPlans, and its authorized employees and representatives, within or without the Philippines, in accordance with the Data Privacy Act and its implementing rules and regulations, of all such personal and/or sensitive personal information in this form, and all included attachments, solely for all purposes relevant to the enforcement and maintenance of my plan contract, and for all purposes deemed fit by PhilPlans, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk assessment, underwriting and administration of insurance coverage and claims, data analytics and data sharing with PhilPlans.

I also agree that my contact details may be utilized by PhilPlans to provide relevant updates of my plan, as well as company and product developments. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured.

Lastly, I agree that PhilPlans may store the same for the duration of the contract and a reasonable time thereafter.

Dated this _______ day of__________ ___________ year_______ at ___________________________________, Philippines.

I HEREBY CERTIFY THAT I HAVE FULLY READ AND UNDERSTOOD THE BENEFITS AND FEATURES OF THIS PLAN AND AGREE TO BE BOUND BY THE PROVISIONS OF THE PLAN CONTRACT.

WITNESS: ______________________________
REINSTATING SALES COUNSELOR (SIGNATURE OVER PRINTED NAME)

____
SC CODE/AGENCY/REGION NAME

1. ______________________________
SIGNATURE OVER PRINTED NAME OF PLANHOLDER

2. ______________________________
SIGNATURE OVER PRINTED NAME OF PLANHOLDER

FOR CHECK PAYMENTS (To be filled-out by BSS)		**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.	

Clsanchez 6.1.2018