

P.R Date:

TK.....

**APPLICATION FOR REINSTATEMENT AND DECLARATION ON HEALTH
CONDITION ON THE LIVES OF JUVENILES.**

Policy No:Premium Due Date.....

Name of Insured/Policy Owner.....

I, hereby submit this Application for Reinstatement of above

captioned policy and declare that.....

My son/daughter, is in as good health as when I signed the declarations made to authorized Company Agent which constituted my application for insurance on his/her life in CHARTERED LIFE INSURANCE COMPANY and that, since that date, there has been no change in his/her family record, nor has he/she had any illness or disease ,nor has he/she consulted or been examined by any physician, nor has he/she done any medical tests, including blood test for antibodies to the AIDS virus (Human Immune Deficiency Syndrome), and no application has been presented for new insurance, change in plan or reinstatement which was declined, postponed, withdrawn, or modified in kind, amount or rate (except as noted below)* and I understand that the reinstatement of this policy is conditioned on the truth of the above statement. I also understand that the reinstatement of this policy is conditioned on the truth of the above statement. I also understand that, notwithstanding any provision to the contrary in the policy, the policy, if reinstated or modified in such a manner to increase the risk, shall become contestable but shall be incontestable after it has been in force during the life time of the insured for two years from the date of Reinstatement, except for non-payment of premium.

*Exceptions.....

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Name & Signature of Financial Associate / Medical Examiner with SEAL and ID No.

Full Name & Signature of the Applicant

Signed at: this..... day of 20.....

Witnessed by: _____
BM/ ASM Name

Signature & Date

Code No.