



STATEMENT PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CHAPTER 142), YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.



Please remember to...

-  Countersign any amendments
- Ensure that the appropriate boxes are checked
-  Note that Submission Cut-off time is 3pm

And for Corporate Policies...

- Enclose photocopies of NRIC/Passport of authorised signatories
- Enclose copy of the latest ACRA business profile extracted not more than 3 months from submission date

1 POLICY INFORMATION

Full Name of Owner NRIC/Passport No.

Policy Number

2 NAME(S) OF INSURED PERSON(S)

A Life Insured

B Payor

C Payor's Spouse/Other Insured

For more than 1 Other Insured(s), please attach additional Reinstatement Form

3 HEALTH DECLARATION OF INSURED PERSON(S)

- Statement of Insurability is declared by Life Insured and Owner. However, if the Life Insured is under 16 years old, the Owner will be making the declaration.
- If a material fact is not disclosed in this form, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Representative but was not included in the form. Please check to ensure you are fully satisfied with the information declared in this form.

	A	B	C												
	Life Insured	Payor	Payor's Spouse / Other Insured												
1a. Please provide your current Height.	[] m	[] m	[] m												
1b. Please provide your current Weight.	[] kg	[] kg	[] kg												
1c. Has your weight changed in the last 12 months? <i>If Yes, please provide the following details.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Insured Person</th> <th style="width: 40%;">Weight Change</th> <th style="width: 45%;">Reason</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">A</td> <td><input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg</td> <td></td> </tr> <tr> <td style="text-align: center;">B</td> <td><input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg</td> <td></td> </tr> <tr> <td style="text-align: center;">C</td> <td><input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg</td> <td></td> </tr> </tbody> </table>	Insured Person	Weight Change	Reason	A	<input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg		B	<input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg		C	<input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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C	<input type="checkbox"/> Gain <input type="checkbox"/> Loss [] kg														
2a. Since the inception of the Policy, has there been any change in your health status, occupation or country of residence? <i>If Yes, please provide the following details.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Insured Person</th> <th style="width: 30%;">Change</th> <th style="width: 55%;">Details</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">A</td> <td><input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence</td> <td></td> </tr> <tr> <td style="text-align: center;">B</td> <td><input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence</td> <td></td> </tr> <tr> <td style="text-align: center;">C</td> <td><input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence</td> <td></td> </tr> </tbody> </table>	Insured Person	Change	Details	A	<input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence		B	<input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence		C	<input type="checkbox"/> Health Status <input type="checkbox"/> Occupation <input type="checkbox"/> Country of Residence		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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RI-2023-07



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	A	B	C																								
	Life Insured	Payor	Payor's Spouse / Other Insured																								
2b. Have you ever been deferred or declined for Life, Critical illness, Accident, Health insurance, offered insurance with restricted benefits or other than at standard rates? <i>If Yes, please provide the following details.</i> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:15%;">Insured Person</th> <th style="width:25%;">Insurance Company</th> <th style="width:60%;">Details</th> </tr> </thead> <tbody> <tr><td style="text-align:center;">A</td><td></td><td></td></tr> <tr><td style="text-align:center;">B</td><td></td><td></td></tr> <tr><td style="text-align:center;">C</td><td></td><td></td></tr> </tbody> </table>	Insured Person	Insurance Company	Details	A			B			C			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
Insured Person	Insurance Company	Details																									
A																											
B																											
C																											
2c. Since the inception of the Policy, have you engaged in or do you intend to engage in any hazardous pastimes or activity e.g. parachuting, hang gliding, motor sport of any kind (car, boat, motor cycle, go kart), underwater diving, rock climbing, mountaineering and/or flying other than as a fare paying passenger on a licensed commercial airline? <i>If Yes, please provide the following details and complete the relevant questionnaire.</i> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:15%;">Insured Person</th> <th style="width:85%;">Activity/Avocation</th> </tr> </thead> <tbody> <tr><td style="text-align:center;">A</td><td></td></tr> <tr><td style="text-align:center;">B</td><td></td></tr> <tr><td style="text-align:center;">C</td><td></td></tr> </tbody> </table>	Insured Person	Activity/Avocation	A		B		C		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																
Insured Person	Activity/Avocation																										
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B																											
C																											
2d. Since the inception of the Policy, have you travelled outside of Singapore other than for holidays? <i>If Yes, please provide the following details.</i> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:15%;">Insured Person</th> <th style="width:20%;">Reason</th> <th style="width:20%;">City</th> <th style="width:20%;">Country</th> <th style="width:25%;">Duration</th> </tr> </thead> <tbody> <tr> <td style="text-align:center;">A</td> <td> <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing </td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align:center;">B</td> <td> <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing </td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align:center;">C</td> <td> <input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing </td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Insured Person	Reason	City	Country	Duration	A	<input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing				B	<input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing				C	<input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
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C	<input type="checkbox"/> Business <input type="checkbox"/> Personal <input type="checkbox"/> Residing																										
2e. Are you in the process of filing a claim or have you ever made a claim against any insurance company in respect of any Disability, Critical Illness, Medical, Hospitalization, Accident or Life insurance? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width:15%;">Insured Person</th> <th style="width:10%;">Insurance Company</th> <th style="width:10%;">Type of Plan</th> <th style="width:30%;">Description of Claim</th> <th style="width:10%;">Date of Claim</th> <th style="width:15%;">Claim Amount</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/>A <input type="checkbox"/>B <input type="checkbox"/>C</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/>A <input type="checkbox"/>B <input type="checkbox"/>C</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/>A <input type="checkbox"/>B <input type="checkbox"/>C</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Insured Person	Insurance Company	Type of Plan	Description of Claim	Date of Claim	Claim Amount	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C						<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C						<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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2f. Do you have any symptom or medical concern for which you have not consulted a doctor or had any consultation, testing or investigation recommended by a doctor which has not been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																								
2g. Are you planning or have been advised to have a medical check up, surgery or be hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No																								

If any of the answers to Question 2f & g is "Yes", please indicate the Question number, respondent and provide details below.

Question	Insured Person	Condition/ Diagnosis	Year at onset	Test performed, dates & results	Treatment & Medication	Doctor/Hospital/ Clinic consulted
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C					
	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C					

4 DECLARATION & AUTHORISATION

1. I/We declare that no material facts, that is facts likely to influence the assessment of this Application for Reinstatement have been withheld and to the best of my/our knowledge and belief the information given here is true and complete.
2. I/We agree to inform Manulife if there is any change in the state of health, occupation or activity of the Insured between the date of this application or medical examination and the issue of the above benefit. On receiving the information of any change, Manulife is entitled to accept or reject my application.
3. I/We have read the Section 25(5) Insurance Act (Cap 142) warning stated on this Form.
4. Applicable for submission via Facsimile / Electronic mail ("Electronic Services") -
I/We hereby authorise Manulife to carry out the above-mentioned policy transaction(s) on my/our Policy received via Electronic Services.
I/We acknowledge that Manulife is not responsible for verifying the authenticity of the instructions given by me/us or purported to be given by me/us. Manulife reserves the right to withhold or disallow the execution of instructions for verification or other purposes and shall not be liable for any losses incurred in consequence. I/We agree that Manulife shall not be liable for any losses arising from instructions lost in transmission whether due to breakdown in the system or otherwise. Manulife retains full authority and discretion to amend the terms and manner of use of the Electronic Services (including terminating the use of such Electronic Services) at all times. Please note the transmission of instructions via Electronic Services shall be evidenced by the receipt of a successful transmission report(in the case of facsimile) or message (in the case of electronic mail).
5. I/We agree to indemnify and hold harmless Manulife from and against any and all demands, claims, actions, damages, suits, proceedings, assessments, judgments, costs, losses (whether direct, indirect, special or consequential) including legal costs, and other expenses arising from or in connection with Manulife accepting and acting on these instructions (including where relevant, the use of the Electronic Services).
6. I/We agree that the personal data collected in this form will be used by Manulife for the purpose of complying with my/our request and other related purposes only.
7. I/We further confirm that I/we have read and understood and hereby consent to the collection, use, disclosure and processing of my/our personal data in accordance with and agree to be bound by Manulife's Statement of Personal Data Protection, as may be amended by Manulife from time to time. I/We have obtained a copy of Manulife / Statement of Personal Data Protection by: (a) downloading a soft copy from www.manulife.com.sg; or (b) obtaining a hard copy from Manulife.

Signature of Owner/Assignee

Name

Contact No. Date

Signature of Life Insured (16 years and above)

Name

Contact No. Date

Signature of Payor

Name

Contact No. Date

Signature of Payor's Spouse/Other Insured

Name

Contact No. Date

Additional Authorisation for Policy under a Trust

Section 49L (Insurance Act)

- Who to sign:
Any Trustee of the policy who is not the Owner
OR all Beneficiaries 18 years and above
Trustee can be appointed by the Owner via Nomination of Beneficiary Form 3
- Proceeds payable to:
Trustee(s) **OR** All Beneficiary(ies)

Section 73 (Conveyancing & Law of Property Act)

- Who to sign:
All Trustee(s) of the Policy
- Proceeds payable to:
Trustee(s) for the benefit of the Beneficiary(ies)

.....
Signature of Trustee/Beneficiary

Name Date

NRIC No. Contact No.

.....
Signature of Trustee/Beneficiary

Name Date

NRIC No. Contact No.

.....
Signature of Trustee/Beneficiary

Name Date

NRIC No. Contact No.

.....
Signature of Trustee/Beneficiary

Name Date


NRIC No. Contact No.

If you wish to understand the list of purposes for which your personal data may be used or disclosed, you may refer to the Statement of Personal Data Protection located at our website (www.manulife.com.sg)

Need Help?

Please contact your **Financial Representative** for further assistance. Alternatively, you may call our Client Services Officers at **6833 8188**.

Completed?

You may submit the completed and signed form with all relevant documents.
 **Mail –8 Cross Street #15-01, Manulife Tower, Singapore 048424**