



APPLICATION FOR REINSTATEMENT

[] LP • [] EP • [] TP

Contract No.	Planholder's Name (Last, First, M.I.)	
Reinstatement Date (mm/dd/yyyy)	Address:	
Tel. No.:	Mobile Number:	E-mail Address:

I hereby request for reinstatement of the above-mentioned Pre-need Contract which has been automatically terminated and cancelled as provided in the pertinent provisions of the Contract, due to my failure to pay installments within sixty (60) days from due date.

I understand that the acceptance and approval of this request for reinstatement by Loyola is subject to the provisions stated above, and subject further to the following conditions:

1. That I shall be considered a new applicant for purposes of insurance coverage and shall be subject anew to the contestability period.
2. That I shall pay in full all overdue installments with interest from the due date of each at the rate of 15% per annum.
3. That I shall abide with the existing policies of Loyola at the time of reinstatement.

I understand further that if my request for reinstatement is not accepted and approved by Loyola because of insurance declination, the amount which I shall have paid in connection with this request for reinstatement shall be treated merely as deposit to be refunded to me less administrative cost and expenses upon notice of non-acceptance. All other previous payments shall be forfeited in favor of Loyola as liquidated damages.

For Education and Timeplan Only:

It is also understood that if this request is denied due to insurance declination, I hereby request for:

reinstatement without insurance coverage.

I hereby certify that all the questions stated in Statement of Health, at the back hereof, are understood and answered by me to the best of my knowledge and understanding.

ARREARAGES:

No. of Months

Total Arrears

Interest Charges

Reinstatement Fee

Other Charges

Total Amount Due

OR Number

OR Date

I acknowledge that I have received and understood the above conditions, to which I freely and voluntarily give my consent thereto.

PLANHOLDER (Signature over Printed Name)

DATE (mm/dd/yyyy)

Assisted by:

PLANNING EXECUTIVE (Signature over Printed Name)

DATE (mm/dd/yyyy)

For LOYOLA Office Use Only:

Received by:

SOA/CA (Signature over Printed Name)

Date:

(mm/dd/yyyy)

Approved by:

ESD/SMD (Signature over Printed Name)

Date:

(mm/dd/yyyy)

STATEMENT OF HEALTH

Planholder's Name (Last, First, M.I.)	Date of Birth
Contract No.	Occupation
Address:	

ANSWER THE FOLLOWING QUESTIONS BY "YES OR NO"		Use this space or additional sheet to give full details of questions 1 or 2 answered "NO" or to 3 to 6 answered "YES". All Statements contained on that additional sheet are hereby made part of this form. (In answer to questions 5 & 6, give date, symptoms, duration, treatment results, name of doctor, hospital and address)
1. Are you now actively at work on a regular full time basis?		
2. Are you in good health?		
3. Has any application on your life for life, accident, or hospitalization insurance been declined, postponed or modified?		
4. Have you any deformity, impairment of sight, hearing, or loss of any part of the body or other physical defects?		
5. Have you during the past five (5) years had:		
a. Any injury, ailment or disease;	a. _____	
b. Consulted or been treated by any physician or medical practitioner?	b. _____	
c. Any surgical operations?	c. _____	
d. Any medical examination or check-up?	d. _____	
6. Have you ever been confined in any hospital, clinic or similar institution?		
7. FOR FEMALE USE ONLY: Are you pregnant?		

I hereby state and represent that the above answers and exemptions are all true and correct. I agree that a question left unanswered shall have the same effect as a "NO" answer. Effective reinstatement of the Contract/Certification is being conditioned on truth of the above statements. I agree that LOYOLA shall not be liable for any loss which may occur prior to compliance with LOYOLA's requirements for this application and actual approval thereof. I further agree that LOYOLA may in its own discretion without offering any reason therefore reject this application or request the applicant to furnish additional evidence of insurability.

Signed at _____ this _____ day of _____ 20 _____.

WITNESSED BY:

 (Signature over Printed Name)

 Planholder