KAISER INTERNATIONAL
HEALTHGROUP, INC

Ground Floor King's Court 1 Building
2129 Chino Roces Avenue, Makati City
Tel No. (02) 274-8202; 274-8203; 274-8205 Fax No. (02) 811-1878

APPLICATION FOR REINSTATEMENT OF PLAN AGREEMENT

(Please print data legibly)

Last Name:	First Name:	Middle Name:	
Permanent Residence Address:	Telephone No:	Birth Date:	Plan Name:

I hereby apply for reinstatement of my Plan Agreement No. 80880-10000_____-00-CORE/RIDER by the following method:

[_] UPDATING: Payment of all installment in arrears with surcharge duly computed by KAISER plus P300.00 Processing Fee
[_] REDATING: Payment of one installment plus P300.00 Processing Fee

I have paid, in connection with this application for Reinstatement the Amount of _____under OR No._____ on _____.

HEALTH DECLARATION

I hereby represent and declare to the best of my knowledge that:

[a] I am not more than 65 years.
[b] I have not been confined in any hospital, sanitarium or infirmary, nor received medical or surgical treatment in the last 12 Months.

EXCEPTIONS:

_____
_____
_____

I hereby represent that each of the foregoing statement is true and correct. I agree that if no exception is listed in the blank space provided for such exception, it shall have the same effect if the word "NONE" was written therein.

I agree that the said Plan Agreement shall not be considered until this application is approved by the Company at its Head Office during my lifetime and good health and until all other requirement are fully satisfied. I further agree that prior to the approval of this application, any payment made or to be made shall be considered as a deposit only. If I am no longer insurable and when applicable to my plan type, I hereby authorized the company to reinstate my plan without insurance coverage; otherwise, I understand that if my request is not accepted and approved by Kaiser International Healthgroup, Inc. because of insurance declination, that amount which I shall have paid in connection with this application for reinstatement shall be treated merely as a deposit to be refunded to me upon notice of non-acceptance and disapproval. In case of reinstatement by redating, I agree to change of the maturity date of the pension benefits.

I agree that the approval of the reinstatement is conditioned on the truth of the above statements and shall be contestable at any time within two (2) years from the date of approval hereof, for fraud or misrepresentation of any material facts herein stated.

I further agree that the company has the sole discretion to reject this application for reinstatement or to request me to furnish additional evidence of insurability before acting on my application.

Done at _____ this _____ day of _____.

WITNESS: _____
Reinstating Sales Counselor
(Please sign over printed name)

_____
Signature of Planholder

Agency Name: _____
Region Name: _____

For Kaiser International Healthgroup Inc. Use Only:

_____ _____
RECEIVED BY / DATE CHECKED BY / APPROVED BY:

No: _____

Revised 01-17-2015