KAISER INTERNATIONAL
HEALTHGROUP, INC
Ground Floor King's Court 1 Building
2129 Chino Roces Avenue, Makati City
Tel No. (028) 777-1036; (028) 274-8203; (028) 772-5893 Fax No. (028) 811-1878

APPLICATION FOR REINSTATEMENT OF PLAN AGREEMENT

(Please print data legibly)

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

I hereby apply for reinstatement of my Policy No._____-00 ☐ CORE / ☐ ULTIMATE 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 (1) installment plus P300.00 Processing Fee

HEALTH DECLARATION

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

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

EXCEPTIONS:

_____
_____
_____

In connection with this application for Reinstatement, I paid the amount of_____on_____.

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 as if the word "NONE" is written therein.

I agree that the said Plan Agreement shall not be reinstated until this application is approved by the Company at its Head Office during my lifetime and good health and until all other requirements are fully satisfied. I further agree that prior to the approval of this application, any payment made shall be considered as a deposit only. If I am no longer insurable and when applicable to my plan type, I hereby authorize the company to reinstate my plan without insurance coverage. Moreover, I understand that if my request is not accepted and approved by Kaiser International Healthgroup, Inc. because of insurance declination, that the amount which I 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 the maturity date of my maturity benefits.

I agree that the approval of the reinstatement is conditioned on the truthfulness of the above statements and is subject to the two (2) years contestability period starting upon the approval of this reinstatement for fraud or misrepresentation of any material facts herein stated.

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

Done at_____this_____day of_____.

WITNESS: _____ _____

Reinstating Sales Counselor
(Please sign over printed name)

Signature over printed name

Agency Name: _____
Region Name: _____

For Kaiser International Healthgroup Inc. use only:

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

FORM NO: _____

HEALTH DECLARATION FOR REINSTATEMENT

Please provide information or explanatory notes for every question with a "YES" answer

1. Have you ever been treated for or ever had any known indication of:

a. Disorder of eyes, ears, nose or throat? NO___YES___

b. Dizziness, fainting, convulsion, headaches, speech defect paralysis or stroke, mental or nervous disorder? NO___YES___

c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder? NO___YES___

d. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs? NO___YES___

e.Neuritis, sciatica, rheumatism. Arthritis, gout, or disorder of the muscles or bones, such as spine, back or joints? NO___YES___

f. Deformity, lameness or amputation? NO___YES___

g. Disorder of skin, lymph glands, cycsts, tumor or cancer? NO___YES___

h. Allergies, anemia or other disorder of the blood? NO___YES___

i.Excessive use of alcohol, tobacco or any habit-forming drug? NO___YES___

2. Do you smoke? NO___YES___

3. Other than above, have you:

a. Had any physical disorder or any known indication thereof? NO___YES___

b. Had a medical examination, consultations, illness, injury, surgery? NO___YES___

c. Been a patient in a hospital, clinic, sanitarium, or other medical facility? NO___YES___

d.Had electrocardiogram, x-ray or other diagnostic test? NO___YES___

e.Diabetes thyroid or other endocrine disorder? NO___YES___

f. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or any other disorder of the heart or blood vessels? NO___YES___

g. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, diverticulitis, colitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach intestine, liver or gall bladder? NO___YES___

4. Have you ever had military service deferment, rejection or discharge because of physical or mental condition? NO___YES___

5. Have you ever applied for or received a pension, payment, or benefit due to injury, sickness or disability? NO___YES___

6. Have you a parent, brother, sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness? NO___YES___

7. Do you engage in any private flying or another hazardous activities? NO___YES___

8. HIV or AIDS - related complex or conditions? NO___YES___

9. Have you within the past 5 years:

a. Tested positive for antibodies to the HIV Virus? NO___YES___

b. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed? NO___YES___

10. FOR FEMALE ONLY:

a. Have you ever had any abnormal menstruation, pregnancy, childbirth or disorder of the female organs or breast? NO___YES___

b. Are you now pregnant? NO___YES___

c. are you taking contraceptive pills? NO___YES___

11. Have you ever been rejected or terminated for medical insurance including KAISER program, or have been offered insurance at a higher (rated-up) premium? NO___YES___

_____ _____

Signature Over Printed Name of Proposed Member Date

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

Date

_____

I hereby authorize any person, organization or entity that has any record on or knowledge of my health conditions to give to Kaiser International Healthgroup, Inc. any and all information that the Company may desire and which is relative to any consultation, treatment or any other medical advice or examination I had. A photostat (or similar copy) of this authorization shall be as valid as the original. This information is in connection with my application for reinstatement of plan agreement.

_____

Signature Over Printed Name of Proposed Member

For Application with Payor other than Proposed Member:

I hereby authorize any person, organization or entity that has any record on or knowledge of my health conditions and that of the proposed member to give to Kaiser International Healthgroup, Inc. any and all information that the Company may desire and which is relative to any consultation, treatment or any other medical advice or examination I/we had. A photostat (or similar copy) of this authorization shall be as valid as the original. This information is in connection with my application for reinstatement of plan agreement.

_____

Signature Over Printed Name of Legal Guardian/Owner or Payor

_____

Signature Over Printed Name of Proposed Member

EDITION DATE: 07212021

FORM NO: _____