APPL. REC'D DATE: _______________
POLICY NO: ____________________
BRANCH: ______________________
ADVISOR: _____________________

APPLICATION FOR REINSTATEMENT OF COUPON PLANS

SECTION 1 LIFE INSURED

Date of Birth
____ ____/____/____
First Name Middle Name Last Name Title (dd/mm/yy)

Telephone # Home ____________ Mobile ______________ E-mail address* ______________________

Method of Payment: ☐ Pre-Authorized Payment ☐ Salary Deduction. Is banking information or authorization still in place? YES ☐ NO ☐

If response is "No", indicate the new arrangements here ______________________Date salary deduction recommenced _________

SECTION 2 CANCER PLANS

1. Have you ever been treated or diagnosed with any form of cancer? YES ☐ NO ☐
2. Have you ever been diagnosed with a condition that potentially could be cancerous, such as elevated PSA, Abnormal Pap Smear or abnormal biopsy? YES ☐ NO ☐
3. Have you ever been treated or diagnosed as being HIV positive? YES ☐ NO ☐

If "yes" to any of the above, unfortunately, you are not eligible for reinstatement of this plan.

I declare that the answers shown above are complete and true and I understand that failure to disclose relevant information may invalidate this contract or affect future benefits. I understand further, that no claim can be made under this contract before this reinstatement has been in force for 180 days and that coverage under this plan.

INSURED'S SIGNATURE: ______________________________ DATE: ________________________

WITNESS: ____________________________________ DATE: ________________________

SECTION 3 TRIPLE PROTECTOR/TRIPLE PROTECTOR PLUS

1. Have you ever been treated or diagnosed with any form of cancer? YES ☐ NO ☐
2. Have you ever been diagnosed with a condition that potentially could be cancerous, such as elevated PSA, Abnormal Pap Smear or abnormal biopsy? YES ☐ NO ☐
3. Have you ever been treated or diagnosed as being HIV positive? YES ☐ NO ☐
4. Have you ever been treated or diagnosed with a Heart Attack or Angina Pectoris? YES ☐ NO ☐
5. Have you ever been treated or diagnosed for a stroke or Transient Ischaemic Attack (TIA)? YES ☐ NO ☐

If "yes" to any of the above, unfortunately, you are not eligible for reinstatement of this plan.

I declare that the answers shown above are complete and true and I understand that failure to disclose relevant information may invalidate this contract or affect future benefits. I understand further, that no claim can be made under this contract before this reinstatement has been in force for 180 days and that coverage under this plan.

INSURED'S SIGNATURE: ______________________________ DATE: ________________________

WITNESS: ____________________________________ DATE: ________________________

SECTION 4 PLATINUM INVESTOR/ PREMIUM SAVER /UNIVERSAL INVESTOR/UNIVERSAL HOME OWNER/ SAGIGOLD ACCUMULATOR

I understand all the terms and conditions of the plan and that my policy will become effective the day that my correctly completed application for reinstatement accompanied by payment in full of all outstanding premiums is received by the company duly signed and witnessed. I understand further, that the graded benefits under this policy will recommence on the date of reinstatement and that no claim can be made under this contract before this policy has been reinstated.

INSURED'S SIGNATURE: ____________________ OWNER ______________________DATE: ____________________

WITNESS: ____________________________________ DATE: ________________________

SECTION 5 PURPLE SHIELD/LIFE PROTECTOR/L.I.P./GIFT PLAN

Are you now in good health and free from all symptoms and disease? If No, explain below; YES ☐ NO ☐

____

I hereby apply to the Company to reinstate my Purple Shield/Life Protector/LIP /GIFT policy. I understand all the terms and conditions and that my policy will become effective the day that my correctly completed application for reinstatement form, accompanied by payment in full of all outstanding premiums is received by the Company duly signed and witnessed. I understand further, that the graded benefits under this policy will recommence on the date of reinstatement and that no claim can be made under this contract before this policy has been reinstated.

INSURED'S SIGNATURE: ______________________________ DATE: ________________________

WITNESS: ____________________________________ DATE: ________________________

SECTION 6 MAXIMUM PROTECTOR/CRITICAL ILLNESS PROTECTOR

1. Have you ever been treated or diagnosed with any form of cancer? YES ☐ NO ☐
2. Have you ever been diagnosed with a condition that potentially could be cancerous, such as elevated PSA, Abnormal Pap Smear or abnormal biopsy? YES ☐ NO ☐
3. Have you ever been treated or diagnosed as being HIV positive? YES ☐ NO ☐
4. Have you ever been treated or diagnosed with a Heart Attack or Angina Pectoris? YES ☐ NO ☐

If "yes" to any of the above, unfortunately, you are not eligible for reinstatement of this plan.

I declare that the answers shown above are complete and true and I understand that failure to disclose relevant information may invalidate this contract or affect future benefits. I understand further, that no claim can be made under this contract before this reinstatement has been in force for 180 days and that coverage under this plan.

INSURED'S SIGNATURE: ______________________________ DATE: ________________________

WITNESS: ____________________________________ DATE: ________________________

The E-Service Application Form should accompany this application if the client has an E-mail address
Authorized witnesses are Advisors, Sagicor Employees, Justice of the Peace or Notary Public only