

APPL. REC'D DATE:
Policy No:
Branch:
Advisor:

SECTION 1 LIFE INSURED	PLANS A	DVISOR:		
SECTION I LIFE INSURED				
		Date	of Birth	
First Name Middle Name Telephone # Home Mobile	Last Name E-mail addre	Title (dd/mn	• • •	
Method of Payment: ☐ Pre-Authorized Payment ☐ Salary Deducti		· ·		
If response is "No", indicate the new arrangements here SECTION 2 CANCER PLANS		ate salary deduction recommenced _		
		YES NO		
 Have you ever been treated or diagnosed with any form of cancer? Have you ever been diagnosed with a condition that potentially coul elevated PSA, Abnormal Pap Smear or abnormal biopsy? Have you ever been treated or diagnosed as being HIV positive? 		YES NO 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: SECTION 3 TRIPLE PROTECTOR/TRIPLE PROTE				
		VEC NO N		
 Have you ever been treated or diagnosed with any form of cancer? Have you ever been diagnosed with a condition that potentially countries. 		YES NO		
elevated PSA, Abnormal Pap Smear or abnormal biopsy?	,	YES NO		
3. Have you ever been treated or diagnosed as being HIV positive?4. Have you ever been treated or diagnosed with a Heart Attack or Ar	ngina Pectoris?	YES □ NO □ YES □ NO □		
Have you ever been treated or diagnosed with a Fleat Attack of Art Have you ever been treated or diagnosed for a stroke or Transient		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 further, that no claim can be made under coverage under this plan.				
INSURED'S SIGNATURE:	DATE:			
WITNESS:	DATE:			
SECTION 4 PLATINUM INVESTOR / PREMIUM SA OWNER / SAGIGOLD ACCUMULATOR		NVESTOR/UNIVERSAL H	ОМЕ	
I understand all the terms and conditions of the plan and that my policy will be accompanied by payment in full of all outstanding premiums is received by	the company duly signed ar	nd witnessed. I understand further, that	the graded	
benefits under this policy will recommence on the date of reinstatement ar reinstated.	nd that no claim can be mad		y has been	
benefits under this policy will recommence on the date of reinstatement ar reinstated.		DATE		
benefits under this policy will recommence on the date of reinstatement ar reinstated. INSURED'S SIGNATURE:OWNER				
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benefits under this policy will recommence on the date of reinstatement ar reinstated. INSURED'S SIGNATURE:OWNER WITNESS:OWNER SECTION 5 PURPLE SHIELD/LIFE PROTECTOR/Are you now in good health and free from all symptoms and disease? If No, explored the symptoms are disease? If No, explored apply to the Company to reinstate my Purple Shield/Life Protector/L become effective the day that my correctly completed application for reinstate received by the Company duly signed and witnessed. I understand further	DATE: L.I.P./GIFT PLAN cplain below; IP/GIFT policy. I understand atement form, accompanied r, that the graded benefits policy has been reinstated.	YES NO D all the terms and conditions and that m by payment in full of all outstanding p under this policy will recommence on	y policy will premiums is	
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