

Reinstatement Form

In this form, "the Company" means Manufacturers Life Insurance Co. (Phils), Inc. "We", "us", "our", "I", "me" and "my" mean the Policyowner and/or the Life Insured as may be applicable. For policies that have lapsed for more than 24 months, a fully accomplished Non-Medical Form is also needed.

General Information

Policy Number	Email Address	Mobile Number +63
Owner Last Name	Owner First Name	Owner Middle Name <input type="checkbox"/> Do not know / not applicable
Insured Last Name	Insured First Name	Insured Middle Name <input type="checkbox"/> Do not know / not applicable
For Institutional Policyowner, Current Address: (Floor/No., Building/Street, Subdivision/Village, Barangay/District, Town/City, Province/State, Country, Zip Code)		Do you already have a financial advisor for this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No / I don't know, please assign me a new advisor <input type="checkbox"/> I have a preferred advisor (provide name below):

Health Information

In this section, owner information is only required if the policy has a Payor's Benefit.	Insured		Owner	
	Yes	No	Yes	No
1. Have you ever been declined, postponed, charged higher than standard premium rates, or offered modified or restricted benefits for life, critical illness, disability or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever, been told that you have, had symptoms of, or been treated for cancer or lumps/growth of any kind, diabetes mellitus, raised blood pressure, chest pain, heart attack, stroke, cerebrovascular disease, any disease or disorder of the heart or blood vessels (e.g. coronary artery), the lungs, blood, kidney(s), liver, bowel or stomach, pancreas, hepatitis B or C (including Hepatitis B carrier), mental illness, rheumatoid arthritis, HIV or AIDS, alcoholism and/or drug addiction, neurological disorder (e.g. Multiple Sclerosis, Parkinson's disease, Motor Neurone Disease), physical impairments (e.g. loss of sight or hearing), or any other major illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have any of your natural parents or siblings had Dementia (including Alzheimer's disease), Cancer, Cardiomyopathy, Diabetes, Heart Disease, Stroke, Huntington's' Disease, Parkinson's Disease, Polycystic Kidney Disease, Familial Adenomatous Polyposis, Motor Neurone Disease, Multiple Sclerosis or Muscular Dystrophy? If yes, please indicate family member, condition/illness, age at onset and age at death (if applicable).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past 5 years, have you sought, currently seeking, or plan to seek, any treatment at any hospital, clinic, or doctor for any illness, injury, medical advice, operation or treatment and/or for any diagnostic test (such as an ECG, X-ray, blood test, etc.) not mentioned above, (exclude minor ailments like common colds, flu, minor accidental injuries which you have recovered from, routine health check-up with normal results) and/or are you taking medication on a regular ongoing basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently have any signs or symptoms of illness or disease for which you have not sought medical advice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Since this Policy was initially approved or from its last reinstatement, has the Insured or Owner: a. Changed his/her occupation or country of residence? b. Is engaged in extreme sports /activities or hobbies (ex. mountaineering, sky diving, scuba diving, etc)?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
7. How would you describe your smoking habit? <input type="checkbox"/> Never smoke <input type="checkbox"/> Smoke up to 30 cigarettes per day <input type="checkbox"/> Smoke more than 30 cigarettes per day				
8. Insured's Height: _____ <input type="checkbox"/> ft./in. <input type="checkbox"/> cm. Weight: _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg. Owner's Height: _____ <input type="checkbox"/> ft./in. <input type="checkbox"/> cm. Weight: _____ <input type="checkbox"/> lbs. <input type="checkbox"/> kg.				

Remarks: If you responded yes to any, please provide details. Give full particulars, condition, dates, duration and results. Give full names and addresses of doctors, hospitals and clinics. State name of person referred to. Use a blank page if necessary.

Reinstatement Form

Other Information

1. Is the Owner a United States citizen, resident or a resident alien (US Green card holder)?
 Yes, to any, please provide W-9 form and skip question #2 No

2. Does the Owner have a United States Taxpayer Identification Number (SSN/TIN), address and/or telephone number?
 Yes, please provide W-8 Ben form No

3. If the Owner was born in the US, did the Owner renounce his/her US Citizenship? Skip if the owner is not born in the US.
 Yes, please provide W8-Ben form and US Bureau of Consular Affairs' Certificate of Loss of Nationality in the US Form
 No, please provide W9 Form with SSN

4. Will anyone other than the Owner be paying for this policy? Yes, please submit Payor Information Form No

5. Have you or any of your immediate family members or close relationships and associates been entrusted with prominent public position/s in (a) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (b) a foreign State; or (c) an international organization? Yes No

6. Does this policy have a Beneficial Owner (any natural person who directly or indirectly owns or control 20% or more of the shares of a legal entity; or ultimately owns/controls the customer and/or on whose behalf a transaction/activity is being conducted)?
 Yes, please submit Beneficial Owner Form No

Declarations

1. I/we have read the above questions, statements and answers and certify that the information provided above is true, correct and complete based on my/our personal knowledge and official records. If signing for the legal entity identified above, I/we certify that I/we have the capacity to sign for such legal entity. I/we also allow the Company to update my/our records based on the information found in this form and to use such to administer and service the policy. I agree to receive a confirmation receipt to inform me once the changes are effected. If the change I/we requested requires evidence of insurability, I/we agree that the Company will not be able to challenge this policy change after two (2) years from the date the requested change was applied. However, the Company can still challenge the policy change even after the 2-year period has ended for the following reasons:
 - a.) The Company has not received payment for the policy's premium
 - b.) The account value of the variable life policy is not enough to pay the monthly deductions of the Company
 - c.) If the Insured commits suicide within one (1) year from the change or the last reinstatement, the relevant Insurance Code provision will apply. If suicide is not covered, the Company will only pay the refund value.
 - d.) For any other reason allowed by law.
2. I/we agree that the information I/we provided can be processed, collected, used, stored, disclosed, transferred, shared or disposed by the Company, including its employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group, advisors, representatives, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels and its third party service providers in accordance with the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's Privacy Policy available at www.manulife.com.ph/Customer-Privacy-Policy.
3. During the effectivity of the contract/policy, I agree to the following: in case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to my fault, the Company may apply the following: a) measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.
4. In accordance with the Insurance Commission's Circular Letter No. 2016-54, as may be amended from time to time, your (Insured) medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.

 Policyowner Signature Over Printed Name

Date: _____ Place: _____
 (mm/dd/yyyy)

 Insured Signature over Printed Name

Date: _____ Place: _____
 (mm/dd/yyyy)

 Financial Advisor Signature Over Printed Name

Date: _____ Place: _____
 (mm/dd/yyyy)

FA Code: _____

For Manulife use Only

Type of Reinstatement: Straight Redate (for traditional policies only)

Valid IDs: Type: _____ ID# _____ Documents Presented: _____

Documents received and validated by: _____
 Name of CSO Branch Date (mm/dd/yyyy)

Non-Med Form Insured

Declaration of Insurability of Proposed Insured in lieu of Medical Examination

Name (Title, Last Name, First Name, Middle Name Do not know/not Applicable) _____ Date of Birth (MM/DD/YYYY) _____

Present Height: _____ ft./in. cm. **Present Weight:** _____ lbs. kg.

1. Has your mother, father, brother or sister, had diabetes, breast, cervical, ovarian, colon, or other cancer, high blood, heart problem, stroke, hemachromatosis, huntington's disease, polycystic kidney, multiple sclerosis, or any other hereditary disease? Yes (Please provide details below) No

Family Member's Name: (Last, First Middle <input type="checkbox"/> Do not know/not applicable) (Relationship to Proposed Insured)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)	REMINDERS ON DETAILS Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.

	Yes	No	Details
2. Have you ever had or currently having any disease or disorder of:			
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure or any other heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	<input type="checkbox"/>	<input type="checkbox"/>	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered?)	<input type="checkbox"/>	<input type="checkbox"/>	
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRANSMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	<input type="checkbox"/>	<input type="checkbox"/>	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	<input type="checkbox"/>	<input type="checkbox"/>	
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones, and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints, or spine? Amputation, paralysis, deformity (except sprains, and strains which have recovered)?	<input type="checkbox"/>	<input type="checkbox"/>	
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer, and any other cancers?	<input type="checkbox"/>	<input type="checkbox"/>	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	<input type="checkbox"/>	<input type="checkbox"/>	
8. How do you describe your drinking habit? <input type="checkbox"/> Never Drink <input type="checkbox"/> Drink up to 14 bottles of beer (or 200ml of wine) per week <input type="checkbox"/> Drink more than 14 bottles of beer (or 200ml of wine) per week	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you been treated for alcohol or drug abuse during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
10. How do you describe your smoking habit? <input type="checkbox"/> Never Smoke <input type="checkbox"/> Smoke up to 30 cigarettes per day <input type="checkbox"/> Smoke more than 30 cigarettes per day	<input type="checkbox"/>	<input type="checkbox"/>	

Non-Med Form Insured

IF UNDER AGE TWO: Was there any birth difficulty, RH problem, congenital or deformity such as deformed limbs, “blue baby”, lack of mental development, or Down’s Syndrome?

IF UNDER AGE 17: How much weight was gained in the past year? _____ If none or with loss, give details _____

NOTE: The Company performs random testing covering all insurance applicants. Hence, on a case-to-case basis, for this and other such reasons, the Company reserves the right to require medical evidence on the Proposed Insured.

Signed at: _____ this _____ day of _____, 20 ____.

I certify that I have truly read and accurately recorded
on the application the information supplied by the
Proposed Insured.

Proposed Insured and/or Owner/Payor Signature over printed name

Financial Advisor signature and printed name

Non-Med Form Payor

Declaration of Insurability of Proposed Insured in lieu of Medical Examination

Name (Title, Last Name, First Name, Middle Name Do not know/not Applicable) _____ Date of Birth (MM/DD/YYYY) _____

Present Height: _____ ft./in. cm. **Present Weight:** _____ lbs. kg.

1. Has your mother, father, brother or sister, had diabetes, breast, cervical, ovarian, colon, or other cancer, high blood, heart problem, stroke, hemochromatosis, huntington's disease, polycystic kidney, multiple sclerosis, or any other hereditary disease? Yes (Please provide details below) No

Family Member's Name: (Last, First Middle <input type="checkbox"/> Do not know/not applicable) (Relationship to Proposed Insured)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)	REMINDERS ON DETAILS Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.

	Yes	No	Details
2. Have you ever had or currently having any disease or disorder of:			
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure or any other heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	<input type="checkbox"/>	<input type="checkbox"/>	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered?)	<input type="checkbox"/>	<input type="checkbox"/>	
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRANSMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	<input type="checkbox"/>	<input type="checkbox"/>	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	<input type="checkbox"/>	<input type="checkbox"/>	
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones, and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints, or spine? Amputation, paralysis, deformity (except sprains, and strains which have recovered)?	<input type="checkbox"/>	<input type="checkbox"/>	
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer, and any other cancers?	<input type="checkbox"/>	<input type="checkbox"/>	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	<input type="checkbox"/>	<input type="checkbox"/>	
8. How do you describe your drinking habit? <input type="checkbox"/> Never Drink <input type="checkbox"/> Drink up to 14 bottles of beer (or 200ml of wine) per week <input type="checkbox"/> Drink more than 14 bottles of beer (or 200ml of wine) per week	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you been treated for alcohol or drug abuse during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
10. How do you describe your smoking habit? <input type="checkbox"/> Never Smoke <input type="checkbox"/> Smoke up to 30 cigarettes per day <input type="checkbox"/> Smoke more than 30 cigarettes per day	<input type="checkbox"/>	<input type="checkbox"/>	

Non-Med Form Payor

NOTE: The Company performs random testing covering all insurance applicants. Hence, on a case-to-case basis, for this and other such reasons, the Company reserves the right to require medical on the Payor.

Signed at: _____ this _____ day of _____, 20____.

I certify that I have truly read and accurately recorded on the application the information supplied by the Payor.

Payor and/or Owner signature over printed name

Financial Advisor signature and printed name