Manulife China Bank Life Assurance Corporation
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: (1800) 1 888 6268
Website: www.manulife-chinabank.com.ph
Email: phcustomercare@manulife.com

Reinstatement Form

In this form, "the Company" means Manulife China Bank Life. "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 ☐ Do not know / not applicable
Insured Last Name	Insured First Name	Insured Middle Name ☐ 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)

Health Information

In this section, owner information is only required if the policy has a Payor's Benefit	Insured Yes	Insured No	Owner Yes	Owner 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?	☐	☐	☐	☐
2. Have you ever had, 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 Neuron Disease), physical impairments (e.g. loss of sight or hearing), or any other major illness?	☐	☐	☐	☐
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).	☐	☐	☐	☐
4. During the past 5 years, have you sought, currently seeking, or plan to seek, or do you 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?	☐	☐	☐	☐
5. Do you currently have any signs or symptoms of illness or disease for which you have not sought medical advice?	☐	☐	☐	☐
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.)?	☐ ☐	☐ ☐	☐ ☐	☐ ☐

7. How would you describe your smoking habit? ☐ Never smoke ☐ Smoke up to 30 cigarettes per day ☐ Smoke more than 30 cigarettes per day

8. **Insured's Height:** _____ ☐ ft./in. ☐ cm. **Weight:** _____ ☐ lbs. ☐ kg. **Owner's Height:** _____ ☐ ft./in. ☐ cm. **Weight:** _____ ☐ lbs. ☐ 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.

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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 email and/or letter 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 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 https://www.manulife-chinabank.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	Insured Signature over Printed Name	Financial Sales Associate Signature Over Printed Name
Date:_____ (mm/dd/yyyy) Place:_____	Date:_____ (mm/dd/yyyy) Place:_____	Date:_____ (mm/dd/yyyy) Place:_____
		FSA Code:_____

For Manulife China Bank Use Only

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

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

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