Policy Reinstatement

Policy Number: _____

Name of Insured: _____

Job Title: _____

Date of Birth (dd/mm/yyyy): _____ Gender: ☐ Male ☐ Female

Height (cm): _____ Weight (kg): _____

Email Address: _____

Dependants

Name	Date of Birth	Gender	Height (cm)	Weight (kg)	Relationship

1. Have you or any of your dependants consulted a physician in the past 2 years? ☐ No ☐ Yes (explain)

_____

2. Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition? ☐ No ☐ Yes (explain)

_____

3. Have you or any of your dependants been advised to undergo any test, treatment, special diet, medication, procedure, checkup, or hospitalisation? ☐ No ☐ Yes (explain)

_____

4. Have you or any of your dependants incurred any medical expense (or other expense covered by the policy) during the past two years which has not been reported to the Company? ☐ No ☐ Yes (explain & state amount)

_____

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true. I agree that the answers in this form shall be incorporated into the policy and shall, along with statements made in connection with my application and any renewals, form the basis of the reinstated policy.

_____ _____

Signature of the Insured / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date

Arranged and administered by APRIL S.A.S.'s registered subsidiaries:
APRIL Hong Kong Limited
APRIL Singapore Pte Ltd
APRIL Vietnam Company Limited
APRIL Assistance (Thailand) Co Ltd

7/2022

Our Privacy Policy is available at https://asia.april-international.com/en/privacy-policy