# Critical Illness Insurance Reinstatement Form

## Policyholder Information

Full Name

Policy Number

Date of Birth

Phone Number

Email Address

Address

## Reason for Reinstatement

Please specify the reason for requesting reinstatement

## Health Declaration

Describe your current health status

Date of Last Diagnosis (if any)

Details of Any Ongoing Treatment

## Insurance Details

Coverage Amount

Beneficiary Name

## Declaration & Authorization

Declaration

Date

Signature