Application for Policy Reinstatement

Policy No. _____ Insured's Name: _____

Policy Owner's Name: _____ Mobile Number: _____

Email Address: _____

I hereby request to reinstate my lapsed policy. By signing this simplified reinstatement form, I declare that I am in good health, have no physical or mental impairment, perform all my routine activities independently and currently I do not expect to receive any treatment or hospitalization for any ailment or disease. I further declare that I have not consulted or been treated or examined by a doctor for any injury or disease and have not gone through any medical diagnostic test or procedures or been hospitalized for any length of time or had any surgical procedure in the past two years.

Please declare below if you have any medical condition:

I understand that my policy will be reinstated only if I meet all conditions set by MetLife including the payment of outstanding premium/s and fees. Further, I also understand that the reinstatement may not be valid if any material fact about my health is not disclosed in this form. MetLife reserves the right to request for additional medical information to assess my insurability for reinstatement.

The information provided above is accurate to the best of my knowledge.

Policy Owner's Signature: ---------- Date: ----------

Witness Signature: ---------- Date: ----------

Note: The amount waived under reinstatement campaign will be deducted from the surrender value if this policy is surrendered within 2 years from the reinstatement date.