REQUEST FOR **REINSTATEMENT**

CAPITAL LEGACY™

SECTION A Important notes:

1. Please answer the following medical questions below. Your request for reinstatement will be approved on the basis of your answers to them.
2. If approved by Capital Legacy, your reinstatement will commence on the 1st day of the new month from the date of this application.
3. Please ensure your details with us are correct.
4. Reinstatement will apply to all initial product selections. New product or upgrade selections can only be made at the end of the year. Should you wish to cancel or downgrade any product, please communicate this to us separately to this request.
5. Upon successful reinstatement, NO ARREARS will be payable and only the premiums due from the date of reinstatement. All WAITING PERIODS will be applied from the date of reinstatement.

SEND THE COMPLETED FORM TO CAPITAL LEGACY BY:

Fax: 086 552 7195 **Email:** lifeinfo@capitallegacy.co.za **Post:** Private Bag X3, Bryanston, 2021

SECTION B Reinstatement details:

Policy number _____ Policyholder _____

I, the undersigned, confirm my request for reinstatement and acknowledge the notes to this request. I further confirm that my answers to the medical questions to be true and correct.

SECTION C Medical questions:

1) Height in (cm)? _____ Weight in (kg)? _____

2) Have you ever applied for a fully underwritten insurance policy for LIFE COVER ONLY and been refused terms or declined for medical or health related reasons? Yes ☐ No ☐

3) Have you ever tested positive for HIV or received treatment or medical advice for any sexually transmitted diseases, including hepatitis B or C? Yes ☐ No ☐

4) Have you ever been diagnosed with, suffered disease of, or undergone any of the following:

Heart attack ☐ Stroke ☐ Heart muscles or valves ☐ Angina ☐

Stent inserted ☐ Heart bypass ☐ Pacemaker inserted ☐

5) Are you on treatment for high cholesterol following diagnosis by a medical practitioner? Yes ☐ No ☐

6) Have you ever suffered from or been treated for high blood pressure following diagnosis by a medical practitioner? If "Yes": Please answer the questions below. Yes ☐ No ☐

Has your medical practitioner continuously cautioned (i.e. after more than two years of being on treatment) that your blood pressure is poorly controlled, fluctuates drastically or has changed your medication 3 or more times? Yes ☐ No ☐

7) Have 2 or more of your parents or siblings died from heart problems, high cholesterol or high blood pressure before the age of 55? Yes ☐ No ☐

8) Do you suffer from diabetes, raised blood sugar or sugar in the urine? If "Yes": Please answer the questions below. Yes ☐ No ☐

Are you insulin dependent? Yes ☐ No ☐

Do you suffer from any of the following as a result of your diabetes?

Kidney problems ☐ Pain or poor circulation in the feet? ☐ Poor vision ☐

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9) Have you ever been diagnosed with any form of cancer? If "Yes", what cancer were you diagnosed with? Yes ☐ No ☐

Skin cancer ☐ Prostate cancer ☐ Leukaemia/Lymphoma ☐ Lung cancer ☐

Breast cancer ☐ Bone cancer ☐ Blood cancer ☐ Other ☐

Did the cancer spread to your lymph nodes or any other part of your body?	Yes ☐ No ☐
How old were you when you were first diagnosed ? (In years)	
Was the cancer completely removed and did you complete all prescribed treatments?	Yes ☐ No ☐
How long ago did you complete your last treatment ? (In years)	

10) Have you ever been diagnosed with any bleeding, coagulation or clotting disorder? Yes ☐ No ☐

11) Have you ever had any persistent, recurrent or chronic disorder of kidney(s) or liver? Yes ☐ No ☐

12) Have you been diagnosed with any other life threatening condition which currently requires, or may in future require, specialised medical treatment or the assistance of a caregiver (including but not limited to home oxygen, frail care and renal dialysis)? Yes ☐ No ☐

13) Do you intend seeking medical advice in the next 12 weeks (other than routine medical check-ups, dentistry or treatment for minor conditions such as colds, influenza, etc.) Yes ☐ No ☐

14) I confirm that the answers provided above are correct and understand that my benefit may be denied at claim stage should there be any non-disclosure on my part. Yes ☐ No ☐

15) Should your application be declined based on your answers to the above, do you accept:

The Silver Legacy Protection Plan with its initial waiting period?	Yes ☐ No ☐
The Lite Insured Benefit Extender option with its initial waiting period?	Yes ☐ No ☐

SECTION D Contact details: (Only update in the event that the required information has changed)

Email address

Cellular number | Telephone number

SECTION E Banking details: (Only update in the event that the required information has changed)

Bank name | Account type Current ☐ Savings ☐

Account number | Account holder

Debit day 1st ☐ 15th ☐ 20th ☐ 25th ☐

DECLARATIONS BY **APPLICANT**

Signed | Date

Please note that in the event of any modification or variation of this standard form Capital Legacy will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

DECLARATIONS BY **ALTERNATE PAYER**

Signed | Date

Please note that in the event of any modification or variation of this standard form Capital Legacy will regard this form as being invalid and of no force and effect. **Do not sign blank or incomplete forms.**

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