

REQUEST FOR REINSTATEMENT

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 email: lifeinfo@capitallegacy.co.za

SECTION A: REINSTATEMENT DETAILS

Policy number:

Plan Holder:

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 B: 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: Yes No
- 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, fluctuations 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 Poor vision Pain or poor circulation in the feet

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?
 - Was the cancer completely removed and did you complete all prescribed treatments? Yes No
 - How long ago did you complete your last treatment?
- 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: Yes No
- The Bronze Legacy Protection Plan™ with its initial waiting period? Yes No

SECTION C: CONTACT DETAILS (Only update in the event that the required information has changed)

Email address:

Cellular number: Telephone number:

SECTION D: 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 Commencement date: D D M M Y Y Y Y

DECLARATION

Signed at _____ on this _____ day of _____ 20 _____

Signature of Plan Holder and Payer

Signature of Alternate Payer