REINSTATEMENT APPLICATION FORM

This reinstatement application form must be completed in full by the life or lives assured on the contract number stated below. Please use a separate application form for joint lives assured.

Contract number

Life Assured name in full

Country of residence

Date of birth (dd/mm/yyyy)

Sex (please tick) ☐ Male ☐ Female

Occupation and duties

The life assured is reminded of the duty to disclose any changes in health or occupation until they have been notified by RL360 Insurance Company Limited (RL360) in writing that the contract has been reinstated.

Your application will be considered for reinstatement and may be subject to full underwriting.

RL360 reminds the contract owner(s) that in accordance with the Contract Terms and Conditions, no claim for Critical Illness or Waiver of Premium can be submitted if the symptoms first manifest themselves during the period of 90 days following reinstatement.

SECTION 1 – LIFESTYLE DETAILS

This section must be completed in full. If you answer yes to any question please provide additional information in Section 3. Please note all questions must be answered in full, any questions answered with "N/A", "-" or "/" are not acceptable.

1.1 Please insert existing policy number(s) here

1.2 Is there any feature of your lifestyle, work or leisure activities or any other circumstances or fact which might affect or threaten your health or life expectancy? ☐ Yes ☐ No

1.3 Has any insurer ever declined, postponed or accepted an application on your life on special terms, or have you withdrawn an application? ☐ Yes ☐ No

If yes, please state the company(ies), reason(s) and date(s) in Section 3

1.4 Do you have any other existing insurance benefits or are you applying or expecting to apply for insurance benefits with other companies, or do you intend to discontinue any existing cover? ☐ Yes ☐ No

Please state the total amount of life and critical illness cover taken out on your life in the last 12 months, including reinstated policies, and the cover currency in Section 3.

1.5 Please state your height ☐ feet ☐ inches

☐ cms

RL360

1.6 Please state your weight ☐ pounds

☐ kgs

1.7 In the past 12 months have you used tobacco products (cigarettes, cigar or chewing?) ☐ Yes ☐ No

If yes, please state your daily consumption ☐

1.8 Do you intend to fly, other than as a fare paying passenger on licensed commercial airlines or participate in any hazardous pursuits? For example underwater diving, motor racing? If yes, please complete the Supplementary Aviation or Pursuit Questionnaire. ☐ Yes ☐ No

1.9 Will you be out of your stated country of residence for 30 days or more in any one year? If yes, please state full details of countries to be visited, nature of visit and length of stay in Section 3. ☐ Yes ☐ No

1.10 Do you expect or intend to seek a medical opinion within the next 8 weeks? If yes, please state full details in Section 3. ☐ Yes ☐ No

Current medical attendant

Please provide details of your usual medical attendant/attending physician below. If you have no usual medical attendant/attending physician, please provide details of the last doctor you consulted and the reason.

Name of doctor

Number of years attended

Address (in full)

Postcode

Country

Date of last visit (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Reason for last visit

Results of last visit

(If you require more space, please continue on a separate sheet.)

SECTION 2 – MEDICAL QUESTIONS

This section must be completed if any of the contract benefits have been selected. If you answer yes, please provide additional information in Section 3.

Please note all questions must be answered in full, any questions answered with "N/A", "-" or "/" are not acceptable.

2.1 Have you ever been advised to give up tobacco and/or alcohol for any specific reason? ☐ Yes ☐ No

2.2 Have either your drinking or tobacco habits differed in the last five years? ☐ Yes ☐ No

2.3 Please state the specific amount of your average weekly consumption of alcohol (quantity and type).

☐ beer (in litres)

☐ wine (75cl bottles)

☐ spirits (measures)

Do you have or have you ever had any of the following?

2.4 Heart or circulatory disorders eg high blood pressure, stroke, chest pains, heart murmur, palpitations, rheumatic fever, blood vessel disorders, elevated cholesterol? ☐ Yes ☐ No

2.5 Respiratory or lung trouble e.g. asthma, bronchitis, persistent cough, tuberculosis? ☐ Yes ☐ No

2.6 Disorders of the digestive system, gall bladder or liver eg duodenal ulcer, bleeding from the bowel, hepatitis? ☐ Yes ☐ No

2.7 Disease or disorder or infection of the kidneys, bladder or reproductive organs eg protein or blood in the urine, stones, prostatitis, venereal disease, bilharzia? ☐ Yes ☐ No

2.8 Nervous, neurological or mental complaints eg fits, epilepsy, blackouts, persistent headaches, paralysis, anxiety state, depression? ☐ Yes ☐ No

2.9 Ear, eye, nose, throat or skin disorders eg ear discharge, defective vision, recurrent tonsillitis, porphyria, psoriasis, dermatitis? ☐ Yes ☐ No

2.10 Disorders or disease of muscles, bones, joints, limbs or spine eg rheumatism, arthritis, gout, slipped disc, other back or neck troubles? ☐ Yes ☐ No

2.11 Diabetes, sugar in urine, blood or spleen disorders, thyroid or other glandular disorders? ☐ Yes ☐ No

2.12 Cancer, leukaemia, tumour or growth of any kind? ☐ Yes ☐ No

2.13 Are any medicines or drugs currently prescribed for you, or are you receiving any medical or psychiatric treatment or advice or awaiting surgery? ☐ Yes ☐ No

2.14 Have you received, or do you expect to receive, any advice, counselling, treatment or blood tests in connection with AIDS, HIV or an HIV related disorder or any sexually transmitted disease including Hepatitis B? ☐ Yes ☐ No

2.15 Have you ever been counselled or treated in connection with alcohol or drugs? ☐ Yes ☐ No

2.16 Does/has any member of your immediate family:

i) suffer/ed from cancer, diabetes, stroke, kidney disease, multiple sclerosis, heart disease, high blood pressure? ☐ Yes ☐ No

ii) suffer/ed from any hereditary disease? ☐ Yes ☐ No

iii) died before the age of 65? ☐ Yes ☐ No

If you answerered yes to any of the above, please provide full details including your relationship to the family member and their age at diagnosis/death in Section 3.

SECTION 3 – ADDITIONAL INFORMATION

Where any questions(s) have been answered yes, or where further details are required to any answers please provide as much information as possible in the space provided below. Please state which question the details relate to.

Question no.	Details

DATA PROTECTION

This form collects your personal data. We require your personal data so we can provide you with services relating to the performance of your contract. You may ask us to stop processing your data, however this may disrupt the services RL360 can provide to you or may stop us being able to assist you. To find out how long we will keep your data, please refer to our privacy policy at www.rl360.com/privacy. Any data you provide to RL360 may be shared, if allowed by law, with other companies both inside and outside of RL360 and to persons who act on your behalf. Data and information about you can be transferred outside of the Isle of Man and RL360 may be required to provide it to its regulator, its government or anyone else required by law.

RL360 will use your data and information to allow for the administration of your policy, prevent crime, prosecute criminals and for market research and statistics. RL360 will, at all times, make sure that your data and information is only used in ways that are allowed by law.

You can receive a copy of the information RL360 holds about you free of charge by writing to our Data Protection Officer at: RL360, International House, Cooil Road, Douglas, Isle of Man, IM2 2SP, British Isles, or by emailing dpo@rl360.com. We can reserve the right to not send you your personal data in some circumstances. If we do we will write to you setting out the reasons why.

Our full privacy statement can be viewed at www.rl360.com/privacy or can be obtained by requesting a copy from our Data Protection Officer.

DECLARATION

I declare that the above answers are true to the best of my knowledge and that I have not withheld any information that may influence the assessment or acceptance of this application.

I give my express consent for the information in this form to be processed.

I agree that any supplementary questionnaire will form part of my application to the company and that non-disclosure of any material fact known to me may invalidate the contract.

Signature of Life Assured

Date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Witness by introducer

Date (dd/mm/yyyy) ☐☐ ☐☐ ☐☐☐☐

Important notes

The contract will not be reinstated until such time as RL360 has advised the contract owner that the reinstatement application has been accepted and all outstanding premiums due under the contract have been paid.

RL360 accepts no responsibility for any premiums paid until RL360 has received that premium at one of its specified offices.