

DECLARATION OF GOOD HEALTH FOR POLICY REINSTATEMENT

Date: [Insert Date]

To: [Insurance Company Name]

Address: [Insurance Company Address]

Policy Number: [Insert Policy Number]

Policyholder Name: [Insert Full Name]

I, [Insert Full Name], hereby apply for the reinstatement of the above-mentioned insurance policy which lapsed on [Insert Lapse Date] due to non-payment of premiums.

For the purpose of inducing the Company to reinstate this policy, I solemnly declare that:

- I am currently in good health and free from any symptoms of disease or physical impairment.
- Since the date the policy lapsed, I have not suffered any illness, injury, or physical condition, nor have I consulted any physician or medical practitioner.
- Since the date the policy lapsed, I have not been admitted to a hospital, undergone surgery, or been advised to have any medical tests or treatments.
- There has been no change in my family medical history or personal habits that would increase the insurance risk.

I confirm that the statements above are true and complete to the best of my knowledge. I understand that if any information provided in this declaration is found to be false or incomplete, the Company reserves the right to void the reinstatement and decline any future claims.

I have enclosed the required premium payment of [Insert Amount] to cover the overdue period.

Sincerely,

[Signature of Policyholder]

[Print Name]

[Phone Number]

[Email Address]