CERTIFICATE OF GOOD HEALTH FOR POLICY REINSTATEMENT

To be completed by the policyholder
(PLEASE USE BLOCK LETTERS)

1. POLICYHOLDER INFORMATION

Full name	Last	First	M.I.
Policy number			

I understand that this Certificate of Good Health for Policy Reinstatement and any other document submitted with the original application and/or requested by Bupa shall be the basis of any coverage provided, and that no coverage shall take effect unless and until this Certificate is approved by Bupa.
With my signature below, I hereby certify to the best of my knowledge, that NO INSURED PROPOSED FOR COVERAGE under this policy has been diagnosed, has been recommended to receive or received treatment, or has shown symptoms of any physical or mental disorders (except as described in the original application) since the date of my policy's last renewal on _____ .

If the above statement is incorrect, please indicate the name of the insured(s) whose condition has changed, the diagnosis, the clinical or surgical treatment received or recommended, and the results, as well as the name, address and telephone number of the physician(s) and hospital(s) involved in said insured(s) treatment. (PLEASE ADD PAGES IF MORE SPACE IS NEEDED)

Insured's name	Last	First	M.I.
Condition			
Diagnosis			
Clinical or surgical treatment	☐ Received ☐ Recommended		
Results			
Name of physician			
Address			
Telephone			
Name of hospital			
Address			
Telephone			

Is any female proposed for coverage under this policy currently pregnant? ☐ Yes ☐ No
If answered "Yes", please indicate below:

Insured's name		DOB	MM / DD / YY

2. SIGNATURE

Policyholder's signature		Date	MM / DD / YY

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