

REINSTATEMENT APPLICATION

復效申請書

POLICY NUMBER 保單號碼： _____

PRINT NAME (FIRST, M.I., LAST) 姓名(名，別名，姓)： _____

STREET 地址： _____

CITY 城市： _____ STATE 國家： _____ ZIP CODE 郵遞區號： _____

I certify to the best of my knowledge and belief that I have not, since the date of the

Original application for Long Term Care Insurance to Best Meridian Insurance Co.:

我儘我最大的努力瞭解與相信來做下列聲明：自從向 BMI 保險公司申購長期看護險後，就沒有發生下列事件：

- 1) had any injury or illness; 曾發生身體的傷害或罹患疾病
- 2) consulted or been examined by any physician; or 因身體不適而看過醫生、或做過身體檢驗；
- 3) been declined or postponed for Long Term Care or Health Insurance, or been offered a modified or rated policy by any company 曾被保險公司拒保，或長期看護險或醫療險的申請被延遲承保，或是以次標準體被加費承保

The only exceptions* to the above statements are:

對上述曾發生的事項，請詳細說明：

I agree that a copy of this reinstatement application will be attached to the policy. I have listed every exception to items 1, 2, and 3 above.

我同意附上此復效申請書的影本在保單資料中，做為其附件，並清楚詳列上述 1、2、3 項目中曾發生的事件。

Signature of Proposed Insured: _____ Date: _____

被保險人簽名

日期

*If any exception is noted, underwriting approval must be obtained before the policy will be reinstated.

如果有註明發生過上述任何事項，此復效申請必須要經過核保批准後，保單才能恢復生效。

Return this form to:

申請表請寄回總公司

BMI Companies

1320 S.Dixie Highway

6th floor

Coral Gables, FI 33146