



Knights of Columbus Fraternal Assn. of the Phils., Inc.
BC SERVICES DEPARTMENT

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APPLICATION FOR REINSTATEMENT OF BENEFIT CERTIFICATE (BC)

Assured's Name (Please print): _____		BC No: _____
Payor's Name (If Assured is minor): _____		Date of Birth: _____
Residence: _____		KC Council: _____
Telephone: _____	Fax: _____	Mobile Phone: _____ E-mail: _____

QUESTIONS	YES	NO
1. <i>For KC members only:</i> Are you at present KC Member in good standing?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you at present in good health? If no, please give details below.	<input type="checkbox"/>	<input type="checkbox"/>
3. Since the date of your last application for insurance, reinstatement, or modification of this benefit certificate with KC Fraternal:		
a. Have you had any illness, disease, injury, or physical deformities?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you consulted, been treated or operated by any physician /specialist?	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you been confined in a clinic, hospital, or institution?	<input type="checkbox"/>	<input type="checkbox"/>
d. Has there been any death or illness among the immediate members of your family?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has there been any change in your occupation? If so, please furnish us exact duties.	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you within the next 12 months intend to make any aerial flights other than as passenger on scheduled commercial airline?	<input type="checkbox"/>	<input type="checkbox"/>
g. Have lost weight during the past 12 months? How many pounds and why?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you received any disability benefit or compensation from any source?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you applied for a new insurance, change of plan or reinstatement of insurance which was declined, postponed, withdrawn, or modified in kind, amount or rate?	<input type="checkbox"/>	<input type="checkbox"/>
6. <i>For female applications only:</i> Are you now pregnant? If yes, how many months? When was your last menstrual period? (If pregnant, a pregnancy lien shall be attached to your Certificate.)	<input type="checkbox"/>	<input type="checkbox"/>
DETAILS (Dates, symptoms, duration, treatment, results, name of physician and/ or hospital and address):		

I FURTHER AGREE THAT:

1. The payment herein made shall not be binding until and unless this application is actually approved by the Association during the lifetime and good health of Assured; and prior to this approval, the Association shall not be liable for any loss which occurs before the requirements for application are fully fulfilled.
2. The contestability and suicide clause (two-year period) shall start again from the effectivity of this reinstatement.
3. I shall communicate to KC Fraternal any change on the above declarations up to the time that I receive the approval of reinstatement.
4. If the present Benefit Certificate is replaced by a redated Benefit Certificate, I shall surrender the present Certificate and consent to its cancellation, and do forever release and discharge the Association from any or all claims, demands and liabilities whatsoever under the present Certificate.

Signed at _____ this _____ day of _____, _____.

✓ _____
 Signature of Irrevocable Beneficiary over Printed Name
(Please use reverse side for other irrevocable beneficiaries)

✓ _____
 Signature of Assured over Printed Name

✓ _____
 Fraternal Counselor's Signature over Printed Name
(Please indicate FC Code)

✓ _____
 Payor's Signature over Printed Name
(If Assured is Minor)

Please choose your desired method:

- Pure Reinstatement/Back Premium Method**
 Remit overdue and current insurance contributions with interest; full or partial payment of BC loan; and medical fee, if applicable.
- Redating Method**
The issue date shall be amended. Remit difference in contributions with interest; full or partial payment of loan; reissue fee; and medical fee, if applicable. **Surrender BC.**
(Method is not applicable for CSP.)

Amount of Deposit/Payment: _____
 TR/OR No.: _____ Date: _____

FOR HOME OFFICE USE: