डाक जीवन बीमा
Postal Life Insurance

APPLICATION FOR REVIVAL OF POSTAL/ RURAL POSTAL LIFE INSURANCE POLICY

(Please fill in the columns in CAPITAL letters)

1. Name of Insurant (Mr./ Mrs./ Ms.)

First Name	Middle Name	Last Name

2. Communication Address

Village		Taluka	
City		District	
State		Country	PIN

3. Particulars of Policy

i. Policy No.

ii. Sum Assured / -

iii. Date of Acceptance / /

iv. Date of Maturity / /

v. Premium Payment Frequency

Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly ☐

4. Period for which premia is due: _____

_____

5. Reason for non-payment of premiums if any

_____

_____

6. Name of the Post Office at which premia are desired to be paid

i. Name of Sub Post Office

ii. Name of Head Post Office

I hereby declare that I continue to be in good health since the date, the first unpaid premium had become due in respect of above-mentioned policy till this date.

Date:_____

Signature of Insurant
Name:
Phone no.:
Office:
Residence:
Mobile no. :

List of documents to be enclosed: - Medical Certificate