



**HEALTH STATEMENT FORM**

Please fully accomplish this form to facilitate processing of your application.

<b>For Office Use Only</b> Date Received: _____ Time Received: _____ A.M./P.M. Receiving Dept./Office: _____
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**POLICY NUMBER**

Insured _____ Mailing Address _____ _____ _____	Date of Birth: _____ Telephone No: _____ Payment: _____ Date: _____ Receipt No: _____	Application for (Please check applicable box.) <input type="checkbox"/> Removal/Reduction in rating <input type="checkbox"/> Place in Force <input type="checkbox"/> Reinstatement-Please indicate due date of first unpaid premium	<input type="checkbox"/> Addition of Riders <input type="checkbox"/> Change in Plan <input type="checkbox"/> Others _____
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Medically examined for this application?  Yes  No  
 If yes, please indicate: Medical Examiner's Name \_\_\_\_\_ Date Examined: \_\_\_\_\_

QUESTIONS	Insured		Owner		If answer to question 1 is "NO" and/or any of the answers from questions 2-4 inclusive is "YES", please give full details below by indicating the question no., date, symptoms, duration, treatments, results, name of Physician and/or hospital address.
	Yes	No	Yes	No	
1. Are you in good health, free from all diseases, deformities and abnormalities?(If "NO", give details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Since the date of your application for Insurance, latest Reinstatement or Modification of this policy with the Company:					
a) Have you had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b) Have you consulted, been treated or operated on by a physician or undergone any diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c) Have you been confined in a clinic, hospital, institution or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d) Has there been any change in your occupation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e) Has there been any death among the immediate members of your family?(if "YES", give details)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. During the past 5 years, have you applied for a new insurance, change in plan or reinstatement of any insurance with our Company or other insurance companies which was declined, postponed, withdrawn or modified in kind, amount or rate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. If you are a female applicant, are you now pregnant? If YES, how many months? _____months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I agree that:

a) If there be any falsity in the answers contained, the Company may, within two years from approval by the Company of the issuance, amendment or reinstatement of policy applied for, regardless of the date of effectivity requested therefrom by the insured/owner, declare such issuance, amendment or reinstatement null, void and of no effect.

b) The issuance, amendment or reinstatement applied for shall not be considered as effected by reason of any payment made by the insured/owner unless and until this application is actually approved by the Company both within the life time and good health of the insured (and owner if applicable).

c) The Company shall not be liable for any loss which occurs prior to compliance with the Company's requirements for this application and actual approval thereof;

d) Article 1250 of the Civil Code shall not apply to any payment made or to be made by either party under policy; and

e) No agent of the Company shall have authority to waive any of the foregoing conditions.

Place of Signing \_\_\_\_\_ Date of Signing \_\_\_\_ - \_\_\_\_ - \_\_\_\_

\_\_\_\_\_  
 (Signature Over Printed Name)  
 (Required for Insured 7 years old and up)  
**Insured/ Applicant**

\_\_\_\_\_  
 (Signature on Top of Printed Name)  
**Owner**

In case of minor applicant under age 18, I sign statement as parent or guardian

\_\_\_\_\_  
 (Signature Over Printed Name)  
**Witness/ Reinstating Agent**

\_\_\_\_\_  
 (Signature Over Printed Name)  
**Legal Guardian** (If other than Owner)

if witnessed by Agent, indicate if  Original  Reinstating  
 Code No: \_\_\_\_\_ Agent's NM Authority: \_\_\_\_\_  
 Approval for pick-up  Approval by mail

**AUTHORIZATION TO FURNISH MEDICAL INFORMATION**  
 (The form below should be completed and signed)

I/We hereby authorize any person, organization, or entity that has any record of knowledge of my health and/or that of \_\_\_\_\_ to give to the Philippine American Life and General insurance Company any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This authorization is in connection with the application for reinstatement/policy change/removal or reclassification of rating therefrom. A photographic copy of the authorization shall be valid as the original.

\_\_\_\_\_  
**Signature of Proposed Insured**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Signature of Owner**

\_\_\_\_\_  
**Signature of Legal Guardian**