APPLICATION FOR GROUP INSURANCE & STATEMENT OF HEALTH

PHILAM LIFE
An AIA Group Company

Corporate Solutions

Application for: ☐ Employee/Member ☐ Dependent	Last Name / First Name / Middle Name	Date of Birth: Month / Day / Year

Name of Employer or Group	Group Policy No.

Total Amount of Insurance Involved	Amount of Existing Insurance	Additional Amount Applied For	Height	Weight
P	P	P	ft/in	lbs

Please check ☑ reason for submitting Health Statement	☐ LATE ENROLLMENT	☐ OVER AGE LIMIT	☐ REINSTATEMENT	☐ AMOUNT OVER SCHEDULED LIMIT

Please answer the following questions by checking the "Yes" or "No" box.

	YES	NO
1. Are you now actively at work or performing your normal daily activities?	☐	☐
2. Have you:		
a. Ever flown in an aircraft other than as a fare-paying passenger?	☐	☐
b. Ever driven a motorcycle or engaged in auto or motorboat racing, sky diving, scuba diving, or other hazardous avocation?	☐	☐
c. Ever had any application for insurance or reinstatement of insurance declined, postponed or modified in amount, plan or rate?	☐	☐
3. Have you:		
a. Ever taken habit-forming drugs or substances, alcoholic drinks to excess, or had advice or treatment for such habit or other addiction?	☐	☐
b. Ever had medical consultation or treatment pertaining to:		
i. brain or nervous system?	☐	☐
ii. lung or respiratory system?	☐	☐
iii. kidney or urinary system?	☐	☐
iv. heart or blood vessel?	☐	☐
v. stomach or other abdominal organs?	☐	☐
vi. reproductive organs or breast?	☐	☐
vii. diabetes, cancer, tumor or blood diseases?	☐	☐
viii. AIDS, HIV (Human Immuno-diffeciency Virus) infection or a condition associated with either?	☐	☐
c. Ever had a positive blood test for AIDS or HIV infection?	☐	☐
d. Ever had consultation, hospitalization or surgical operation due to any condition not mentioned above during the past 5 years?	☐	☐
e. Any mental impairment, physical defect, tumor or lump or abnormal growth in any part of the body?	☐	☐
f. Ever had during the past 2 years:		
i. Loss of weight; dizzy spells; blood-spitting; abnormality in breathing, urination or bowel movement; or unusual pain in any part of the body?	☐	☐
ii. Medical examinations, X-ray, ECG, blood test or other diagnostic tests?	☐	☐

Use this space or the reverse hereof to give full details of question 1 if answered as "NO", or questions 2 to 4 if answered as "YES". Please indicate question number/letter as reference. Give the date, symptoms, diagnosis, duration, treatment, results, name of attending physician, name and address of hospital/clinic. All statements contained herein and all attachments hereto are hereby made part of this form.

Pls. see back for continuation…

4. ANSWER IF FEMALE: a. Have you ever had any unusual bleeding or abnormality in menstruation, pregnancy or childbirth? b. Are you now pregnant? If so, how many months?	☐ ☐	☐ ☐	

I hereby declare and agree that all statements and answers contained herein and in any addendum annexed to this form, as well as those made to the Medical Examiner (if applicable) contained in a written instrument signed by me and made part of this form, are full, complete and true and that this form shall be part of my application to purchase additional insurance as stated above.

I agree and authorize the Company to collect, record, organize, store, update or modify, retrieve, consult, use, consolidate, block, erase, destroy, transfer, and disclose any information (collected or held) to its affiliated companies (including but not limited to any of its subsidiaries/affiliates in the Asia Pacific Region), financial advisor, accredited/affiliated third parties or independent/non-affiliated third parties, whether local or foreign, with regard to matters or information pertaining to myself and this application or any updates thereof, for any legitimate business purpose, including but not limited to, cross-selling, promote/conduct marketing and direct marketing activities, to provide advice or information covering products or services which the Company believes may be of interest to me, to effectively administer my policy/account, enhance customer services, or to communicate with me for any purpose. This authorization remains valid and subsisting until such time that I have informed in writing the Company of such revocation/cancellation.

I further agree that the insurance coverage under this application is based on the truth of the foregoing declarations and representations and is subject to the provisions of the Group Life Insurance issued by THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY to

_____
(Company/Group)

IN CASE OF A MINOR DEPENDENT, I SIGN THIS CERTIFICATE
IN MY BEHALF AS PARENT AND IN BEHALF OF THE MINOR DEPENDENT

Date	Signature of Dependent /Spouse	Signature of Employee/Member

HOME OFFICE UNDERWRITING ANALYSIS

INDEX SEARCH

IMPORTANT NOTICE: The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws related to insurance and has supervision over insurance companies and intermediaries. It is ready at all times to assist the general public in matters pertaining to insurance. For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMeD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers +632-5238461 to 70, and email address pubassist@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph