

APPLICATION FOR GROUP INSURANCE & STATEMENT OF HEALTH

Corporate Solutions

_	.1:.	tion for							Date of I	Birth	
Application for: Employee/Member											
Dependent Last Na			me First Name Middle Name			Middle Name	Mont	h Da	ay	Year	
Name of Employer or Group								Group	Policy No.		
			Existing Insurance		Additional Amount Applied For		_		W	eight 	
Р					Р			ft/in		lbs	
Please check ☑ reason for LATE submitting Health Statement ENROLLM			MENT O		VER AGE LIMIT	REINSTATEM	ENT AMOUNT OVER SCHEDULED LIMIT				
Plea	ise a	nswer the following questions b	by checking the		lo" box.	Use this space or the reverse hereof to give full details of question 1 if					
			YES	NO	answered as "NO", or questions 2 to 4 if answered as "YES". Please indicate question number/letter as reference. Give the date,					date,	
1.	Are you now actively at work or performing your normal daily activities?					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.					
2.	Hav a.	lave you: . Ever flown in an aircraft other than as a fare-paying passenger?				uns ioini.					
	b.	auto or motorboat racing, sky diving, scuba diving, or other hazardous avocation?									
	 Ever had any application for insurance or reinstatement of insurance declined, postponed or modified in amount, plan or 										
3.	rate? 3. Have you:					-					
	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 pertaining to:	n or treatment								
	i. brain or nervous system?										
	ii. lung or respiratory system? iii. kidney or urinary system?										
		iv. heart or blood vessel?v. stomach or other abdomina	ıl organs?								
	vi. reproductive organs or breast? vii. diabetes, cancer, tumor or blood										
		diseases? viii. AIDS, HIV (Human Imm									
		diffeciency Virus) infection condition associated with	on or a								
	c.	Ever had a positive blood test 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, physitumor or lump or abnormal grapher of the body?									
	f.	Ever had during the past 2 ye									
		 Loss of weight; dizzy spending; abnormality in b 	reathing,								
		urination or bowel move unusual pain in any part									
		ii. Medical examinations, X	(-ray, ECG,								

Pls. see back for continuation...



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4. AN	ISWER IF FEMALE:										
a.		r \square									
	abnormality in menstruation, pregnancy or										
	childbirth?										
b.	Are you now pregnant? If so, how many months?										
	monus?										
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											
					ate business purpose, including but not limited to,						
					mation 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)										
(company croup)											
IN CASE OF A MINOR DEPENDENT, I SIGN THIS CERTIFICATE											
	IN MY BEHALF	<u>AS PARENT</u>	AND IN E	BEHALF OF THE MINOR D	EPENDENT						
	Dete	C:	t of Do		Cinneting of Francisco (March or						
	Date	Signa	ture or De	pendent /Spouse	Signature of Employee/Member						
HOME OFFICE UNDERWRITING ANALYSIS											
		HOME OFFI	CE UNDE	RWRITING ANALYSIS	INDEX SEARCH						
					INDEX CEXTOST						

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