The Philippine American Life and General Insurance Company
Philamlife Bldg., United Nations Avenue, Manila
Telephone No. 528-2000 Fax No. 528-2001 Web Site: *www.ePhilam.com*

HEALTH STATEMENT FORM

REFERENCE NUMBER | | | | | | | | | | |

For Office Use Only
Date Received:
Time Received: A.M./P.M.
Receiving Dept./Office:

Insured _____ Date of Birth: _____
Mailing Address _____ Telephone No: _____
_____ Payment: _____
_____ Date: _____
_____ Receipt No: _____

Application for (Check Applicable Box)
❑ Removal/Reduction in rating
❑ Place in Force
❑ Reinstatement-Please indicate due date of first unpaid premium
❑ Addition of Riders
❑ Change in Plan
❑ Others_____

Medically examined for this application? _____Yes _____No
If yes, please indicate: Medical Examiner's Name _____ Date Examined: _____

QUESTIONS	Insured Yes	Insured No	Owner Yes	Owner No	If answer to question 1 is "NO" and/or any of the answers from questions 2-4 inclusive is "YES", give full details below by indicating the question no., date, symptoms, duration, treatments, results, name of Physician and/or hospital address.
1. Are you in good health, free form all diseases, deformities and abnormalities?(If "NO", give details)	☐	☐	☐	☐	
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?	☐	☐	☐	☐	
b) Have you consulted, been treated or operated on by a physician or undergone any diagnostic test?	☐	☐	☐	☐	
c) Have you been confined in a clinic, hospital, institution or other medical facility?	☐	☐	☐	☐	
d) Has there been any change in your occupation?	☐	☐	☐	☐	
e) Has there been any death among the immediate members of your family?(if "YES", give details)	☐	☐	☐	☐	
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in plan or reinstatement of any insurance with our Company or other insurance companies which was declined, postponed, withdrawn or modified in kind, amount or rate?	☐	☐	☐	☐	
4. If you are a female applicant, are you now pregnant? If YES, how many months? _____months	☐	☐	☐	☐	

I agree that:
a) If there be any falsity in the answer 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 on Top of 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 on Top of Printed Name)
Witness/ Reinstating Agent
if witnessed by Agent, indicate if ☐ Original ☐ Reinstating
Code No:_____ Agent's NM Authority: _____
☐ Approval for pick-up ☐ Approval by mail

_____
(Signature on Top of Printed Name)
Legal Guardian (If other than Owner)

FORM NO. GF-14-1 (0501)

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**