

Name of Insured: _____ Policy Number _____
 Name of Payor or Owner: _____ Sum Insured: _____ Date of Birth: _____
 For the purpose of: _____

This will be submitted if full medical examination was done more than three months before application

	PROPOSED INSURED		OWNER	
	Yes	No	Yes	No
1. Have you ever had, within the past five (5) years, any of the following:				
a. Deformity, impairment of sight, loss of hearing, loss of any part of the body or other physical defects?				
b. Chest pains, high blood pressure or heart disease, blood vessels, blood disease?				
c. Thyroid diseases, Diabetes, and other endocrine diseases?				
d. Disease of kidney, ureters, prostate, and urinary bladders?				
e. Tuberculosis, asthma or lung trouble?				
f. Cancer, tumor, cyst, lymphatics or any other abnormal bodily growth?				
g. Brain, Nervous or mental illness?				
h. Disease of the stomach, liver, gall bladder, intestines or other gastrointestinal and abdominal organs?				
i. Surgical operation, medical consultation or treatment?				
j. X-ray, electrocardiogram, urine, blood or other special tests or examination?				
k. Ever treated or told or is aware that you have AIDS or AIDS-related condition?				
l. Other diseases not mentioned above?				

This refers to question 2 to 4. Since the date of your last declaration of health and medical examination or the last reinstatement of this policy.

2. Have you had any other illness, disease or injury not mentioned above? _____
 (if the answer is "yes," please give details) _____

3. Have you consulted or have been examined by any physician? _____
 (if the answer is "yes," please give details) Consultation date: _____ Reason: _____
 Physician's Name: _____ Tel.No. _____ Address: _____

4. Has there been any change in your occupation? _____
 (if the answer is "yes," please give details) _____

5. Have you applied for a life insurance, change in plan or reinstatement, which is pending or was declined, postponed, withdrawn, or modified in kind, in amount or rate? _____
 (if the answer is "yes," please give details) _____

6. Insured's height: _____ ft _____ in. weight: _____ lbs. Owner's height: _____ ft _____ in. weight: _____ lbs.

7. TO BE ANSWERED BY A FEMALE APPLICANT ONLY:
 * Are you pregnant? If the answer is "yes," how many months _____
 * Any abnormality in menstruation or pregnancy? _____
 (if the answer is "yes," please give details) _____

I hereby clearly understand and agree that my answers to questions Nos. 1 to 12 including details on the above blank space or at the back page of this form are material to the acceptance or denial of this application. I declare that I possess and have full use of all faculties of mind, limbs, sight, speech, and hearing without exception whatsoever, and I am now in good health. I agree that within two (2) years from date of approval of this application, if any of the foregoing statements are found to be untrue in any respect, the company shall have the right to declare null and void and to revoke any contract or contracts that may have been issued by the company upon reliance on the representation and statements made by me. I also agree that any payments made or to be made by me or in my behalf in connection with this application shall be considered as deposit only and shall not bind the company in any manner until this application is finally approved during my lifetime and good health and until all company requirements have been complied with by me. If this application is disapproved, I also agree to accept the refund of all payments made in connection with this application, without interest, and to surrender the receipts for such payment/s. I hereby represent that each of the foregoing statements is true and correct and that I have fully stated all exceptions to each of the statements. I agree that if no exceptions are listed on the blank space provided for such exceptions, it shall have the same force and effect as if that word "none" were written thereon.

Signed at _____ on _____.

 Witness (Signature over Printed Name)

X _____
 Policyowner (Signature over Printed Name)
 (if alien, sign in characters/thumbnails)

 Witness (Signature over Printed Name)

X _____
 Life Insured, if other than the Owner (Signature over Printed Name)