PHILAM LIFE
An AIA Group Company

HEALTH STATEMENT FORM

15F-18F Net Lima Building, 5th Avenue corner 26th Street, Bonifacio Global City, Taguig 1634

Agent Code

POLICY NUMBER

NOTE: Fill out ☐ with block letters. Put ☒ on the tick boxes representing options.

PART I - CONTACT INFORMATION UPDATE

☐ I agree to update my contact information record with Philam Life based on the details in this section.

LAST NAME

FIRST NAME

MIDDLE NAME

Telephone : ☐ Residence ☐ Office

( ) -

ex: (044) 123-4567

Mobile Phone

+ 6 3 - -

ex: +63-900-1234567

E-Mail Address

If you want to receive e-notices in lieu of hard copy billings, accomplish the E-Notice Enrollment Form

Preferred Mailing Address ☐ Residence ☐ Office

House / Building / Lot No., Name of Street

District City Province Zip Code

PART II - HEALTH STATEMENT

For Question 1, please explain a "NO" answer. For Questions 2-4, please explain a "YES" answer. Please use the space provided.

QUESTIONS	INSURED Yes	INSURED No	OWNER Yes	OWNER No
1) Are you in good health and free from any disease, deformities or any abnormalities?				
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 member of your family?				
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in plan or reinstatement of any insurance with our Company or other insurance companies which was declined, postponed, withdrawn, or modified in kind, amount or rate?				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, indicate how many months at the Explanations/Details portion.				

EXPLANATIONS/DETAILS

Indicate symptoms, duration, treatments, results, name of physician and /or hospital and other information.

More space at the back portion

PART III - REQUESTED TRANSACTION/S

☐ **REINSTATEMENT**

☐ **CHANGE PLAN TO:**

☐ **TOP UP**

☐ **INCREASE FACE AMOUNT TO:**

☐ **REMOVE/CHANGE RATING**

☐ **ADD RIDER:**

☐ **Other Transactions**. Please specify:

PART IV - SIGNATURE

I/We hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of the insured to give Philam Life 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 or rating therefrom. A photographic copy of the authorization shall be valid as the original.

I further 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 the 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 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 Signed

Date: m m / d d / y y y y

Owner's Signature over Printed Name | Insured's Signature over Printed Name | Legal Guardian if Insured is Minor | Agent / Witness

PLEASE DO NOT SIGN ON A BLANK FORM.