



APPLICATION FOR CREDITORS GROUP LIFE INSURANCE

GENERAL INFORMATION

Last Name		First Name			Middle Name				
Address									
Contact Details: Home		Office		Cell Phone		Fax			
Date of Birth (MM/DD/YYYY)			Place of Birth			Age	Sex	Height	Weight
Nationality				Occupation					
Name of Employer				Place of Work					
Loan Amount				Loan Term					

NAME OF BENEFICIARY	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

	Y	N	Details of "yes" answers (Use separate sheet if needed)
1. Any weight change (lost/gained) of more than 5 lbs. during the last 5 months? If so, by how many pounds and why?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Have you ever suffered from or sought medical treatment for:	<input type="checkbox"/>	<input type="checkbox"/>	_____
a. epilepsy, fainting attacks or any disorder of mental or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. asthma, bronchitis or any lung problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. chest pain, stroke or any heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. indigestion, ulcer, chronic or recurrent diarrhea, or any other disorder of the digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. diabetes or any disorder of the kidney, liver or urinary system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. rheumatic fever, arthritis, gout or any joint or bone disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. cancer, tumor, enlarged gland or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. unexplained recurrent or persistent fever, weight loss or any skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. any sexually-transmitted disease (such as syphilis or gonorrhea) or viral disease (e.g. hepatitis B or AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. any other illness, injury, disability not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Have you ever been diagnosed as suffering from hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Have you ever been prescribed drugs for this condition?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Have you ever been confined in nursing homes, sanitariums, hospitals for illness, surgical operations, or invasive procedures different from appendectomy, tonsillectomy, adenoidectomy, herniectomy, hemorrhoidectomy, cholecystectomy, child delivery, made within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Have you ever undergone laboratory test or other diagnostic examinations which revealed abnormal results?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Any hospital confinement or surgical procedure being contemplated?	<input type="checkbox"/>	<input type="checkbox"/>	_____

8. Have you ever received treatment with any blood products or undergone blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Any other disease or complaint not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Except as prescribed by a physician, have you ever used shabu, cocaine, heroin, marijuana or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Do you smoke or have you ever smoked more than 10 cigarettes per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Do you take or have you ever taken more than six units of alcohol per day (1 unit = 1/2 pint beer/lager, 1 standard glass of wine, 1 pub measure of spirit)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Have you ever been advised by a physician to stop smoking or drinking alcohol or to drink in moderation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Are you currently taking medications, or are you under medical care of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. For females:			
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any complications with pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Do you have any other application for or reinstatement of life insurance pending? If yes, give details.	<input type="checkbox"/>	<input type="checkbox"/>	_____
With GLAPI	P		_____
With other companies	P		_____

I, the proposed life insured debtor, declare that to the best of my knowledge and belief the above answers and statements are true, complete and correctly recorded; and agree that, this application, if approved, with the answers given in any other declaration which may be required by Generali Life Assurance Philippines, Inc. and which relates to the insurability of the proposed life insured debtor or to change of this policy coverage, shall be the basis for delivery, change or reinstatement of insurance coverage.

I agree that:

1. Generali Life Assurance Philippines, Inc. shall incur no liability by reason of this application or by any reason of any cash paid or settlement made in connection therewith, until this application has been approved by GLAPI during the lifetime of the proposed life insured debtor in good health with no change having taken place in the insurability of the proposed life insured debtor subsequent to the date of this application;
2. All materials facts, being facts which might influence the assessment of this Application, have been truthfully, completely and correctly disclosed in this Application and/or any other, declaration which may be required by GLAPI, it being understood that failure to make such disclosure renders the contract void;
3. If, on the basis of this application and/or any other declaration which may be required by GLAPI, the policy coverage is changed so as to result in an increase in the amount at risk, death by suicide within a period specified in the Suicide Provisions of the policy, is a risk not assumed under the changed policy coverage in respect of any increase in the amount at risk;
4. The validity of insurance on any proposed life insured debtor shall not be contested, except for non-payment of premiums, after his insurance has been in force for one year during his lifetime; and;
5. GLAPI reserves the right to deny claims on the basis of gross fraud or valid grounds recognized under the laws and settled jurisprudence in case of death in any year.

SIGNED AT _____ ON _____

SIGNATURE OVER PRINTED NAME OF WITNESS

SIGNATURE OVER PRINTED NAME OF PROPOSED LIFE INSURED DEBTOR



APPLICATION FOR CREDITORS GROUP LIFE INSURANCE

DEBTOR

Last Name		First Name			Middle Name			
Address								
Contact Details: Home		Office		Cell Phone		Fax		
Date of Birth (MM/DD/YYYY)		Place of Birth			Age	Sex	Height	Weight
Nationality				Occupation				
Name of Employer				Place of Work				
Loan Amount				Loan Term				

NAME OF BENEFICIARY	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

I, the above-named debtor, agree that Generali Life Assurance Philippines, Inc. shall incur no liability by reason of this application or by any reason of any cash paid or settlement made in connection therewith, until this application has been approved by GLAPI while I am alive and actively at work or actively engaged in the exercise of my occupation.

SIGNED AT _____ ON _____

SIGNATURE OVER PRINTED NAME OF WITNESS

SIGNATURE OVER PRINTED NAME OF DEBTOR