

HEALTH STATEMENT FOR LIFE INSURED

APPLICANT'S GENERAL INFORMATION

Company Name				Group Policy No.		
Last Name		First Name		Middle Name		
Date of Birth (MM/DD/YYYY)	Place of Birth	Age	Status	Sex	Height	Weight

	Y	N	DETAILS OF "YES" ANSWERS (PLEASE INDICATE QUESTION NUMBER)
1. Any weight change (lost/gained) of more than 5lbs. 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 the mental or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. asthma, bronchitis, pleurisy, pneumonia, tuberculosis, or any other lung complaint?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. chest pain, high blood pressure, palpitations, shortness of breath, stroke or any heart or circulatory trouble?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. indigestion, gastric, or duodenal ulcer, chronic or recurrent diarrhea or any complaint of the stomach or bowels?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. diabetes or any disorder of the kidneys, liver, bladder or urinary system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. rheumatic fever, arthritis, gout or any bone or joint disease?	<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 have you ever sought medical advice, treatment or a blood test in connection with a viral disease (such as hepatitis B or AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. any other diseases 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 five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Have you ever been 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 mention 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 Generali Life Assurance Philippines, Inc./Generali

Philippines (GLAPI) P _____

With other companies P _____

I, the above-named life insured, 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 Health Statement, if approved, with the answers given in any other declaration which may be required by GLAPI and which relates to the insurability of the life insured or to a change in insurance coverage, shall be the basis for delivery, change or reinstatement of insurance coverage.

I agree that:

1. GLAPI shall incur no liability by reason of this Health Statement or by any cash paid or settlement made in connection therewith, until this Health Statement has been approved by GLAPI while I am alive with no change having taken place my insurability subsequent to the date of this Health Statement;
2. All material facts, being facts which might influence the assessment of this Health Statement, have been truthfully, completely and correctly disclosed in this Health Statement and/or any other declaration which may be required by GLAPI, it being understood that failure to make such disclosure renders the insurance void;
3. If, on the basis of this Health Statement and/or any other declaration which may be required by GLAPI, the insurance coverage is changed so as to result in an increase in the amount of risk, death by suicide, within a period specified in the Suicide Provision of the Policy from the date of this Health Statement, is a risk not assumed under the changed coverage in respect of any increase in the amount of risk;
4. The validity of insurance on any life insured shall not be contested, except for non-payment of premiums, after his insurance has been in force for one(1) 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 INSURED