INSTRUCTIONS TO THE MEDICAL EXAMINER

1. The examination must be done in private. The Bancassurance Sales Executive is not permitted to be present during an examination.
2. Every question asked to the subject(or legal guardian) must be in the dialect or language understood by them, and the answer must be recorded in your own handwriting. The subject (and/or the guardian) must sign in your presence.
3. Any erasure or alteration in the report must be INITIALED by you.
4. The medical examination report must not be suppressed, regardless of your recommendation and regardless of whether the subject or any other person offers to pay medical fee in order to avoid declination.
5. Under no circumstances should a Bancassurance Sales Executive, or any other person, be allowed to review the medical examination report prior to submission to the Home Office.
6. The medical report should be reviewed for completeness of answers before submission.
7. Examiners are not expected to discuss the insurability of the subject of examination with the Bancassurance Sales Executive or (subject of examination) proposed insured.
8. Examiners are not permitted to examine relatives or cases solicited by a Bancassurance Sales Executive who is a relative.

BPI-PHILAM LIFE ASSURANCE CORP.
A subsidiary of Philam Life and an affiliate of BPI

BPI-PHILAM LIFE ASSURANCE CORPORATION (BPI-Philam)
15/F Ayala Life-FGU Center, 6811 Ayala Ave., Makati City 1226, Philippines
Tel. No. 888-5433 (888-LIFE); Hotline No. 89-100
TIN NO. 000-318-213-000

Part II - Application for Insurance to THE BPI-PHILAM LIFE ASSURANCE CORPORATION, Makati, Philippines

Subject _____
(PLEASE PRINT) First Name Middle Initial Last Name

SEX ☐ M ☐ F

Birth Date: _____
Month Day Year

Birth Place: _____

Underline Applicable Items:	Check Box YES	NO
1. Have you ever been treated for or ever had any known indications of:		
a. Disorder of eyes, ears, nose, mouth or throat?	☐	☐
b. Dizziness, frequent headache, loss of consciousness, convulsion paralysis, stroke, or any mental or nervous system disorder?	☐	☐
c. Shortness of breath, persistent cough, blood spitting, asthma, emphysema, PTB, or any chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, heart murmur, heart attack, hypertension, or any disorder of the heart or blood vessels?	☐	☐
e. Recurrent indigestion or abdominal pain, hepatitis, colitis, or any disorder of the liver, pancreas, or gastrointestinal tract?	☐	☐
f. Abnormal urine, nephritis, or any disorder of the kidney, prostrate, or any other genito-urinary organ?	☐	☐
g. Diabetes, goiter, high blood sugar, or other endocrine disorder?	☐	☐
h. Rheumatism, arthritis, deformity, or any disorder of the muscles, bones, joints or spine?	☐	☐
i. Cancer, tumor, cyst, or any abnormal growth?	☐	☐
j. Allergy, anemia, or any disorder of the blood, lymph node or skin?	☐	☐
k. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐
l. AIDS, HIV (Human Immuno-deficiency Virus) infection, or a condition associated with either?	☐	☐
2. Have you ever had a positive blood test for AIDS or HIV infection?	☐	☐
3. Other than above, have you within the past 5 years:		
a. had a medical examination, injury, illness or surgery?	☐	☐
b. been confined in a hospital or other medical facility?	☐	☐
c. had ECG, X-ray, CT scan, ultrasound, blood analysis or other diagnostic test?	☐	☐
d. been advised to undergo a diagnostic test or surgery which was not completed?	☐	☐
4. Are you now under observation or taking treatment?	☐	☐
5. Have you had any change in weight in the past year?	☐	☐
6. Have you ever applied for or received a pension, payment, or benefit due to injury, sickness, or disability?	☐	☐
7. Any family history of high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness? If so, at what age?	☐	☐
8. FOR FEMALES ONLY:		
a. Have you ever had any abnormal menstruation, pregnancy, childbirth or disorder of the female organ or breast?	☐	☐
b. Are you now pregnant? If yes, state the parity and expected date of delivery.	☐	☐
Note: Please specify the LMP (last menstrual period)		

Details of YES answers. (IDENTIFY QUESTION NUMBER. Include dates, diagnosis, duration of illness, results of treatment or tests done, and names and addresses of attending physicians and medical facilities.)

I hereby agree that the above questions and answers shall form Part II of the pending application for insurance on my life and also of any subsequent application for insurance on my life in this Company. Unless I then undergo another medical examination which by its terms is made a part of such application and subsequent applications.

I expressly waive on behalf of myself and of any person who shall have or claim any interest in any policy issued hereunder all provisions of law forbidding any physician, hospital official or employee, or other person who has herefore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me, from disclosing any knowledge or information thereby acquired and from testifying with reference thereto, and I expressly authorize such persons to make such disclosure, all to the exent permitted by law.

Signed at _____ this _____ day of _____, 20 _____

_____
Signature of Medical Examiner

_____
Signature of Subject

_____
Signature of Owner/Legal Guardian

Note:
1. If Subject is unable to write, affix thumbmark and indicate whether right or left.
2. If subject is under 18, the owner (and legal guardian if other than the owner) must also sign his/her name, and indicate his/her capacity below the signature of the ward.

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AUTHORIZATION TO FURNISH MEDICAL INFORMATION

I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____ _____ to give THE BPI-PHILAM LIFE ASSURANCE CORPORATION 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 insurance only. A photographic copy of this authorization shall be as valid as the original.

_____
Signature of Witness

_____
Signature of Subject

_____
Signature of Owner/Legal Guardian

Part III. MEDICAL EXAMINER'S REPORT on _____
(Subject's Name)

EXAMINATION FOR:
- ☐ New Insurance
- ☐ Reinstatement or Policy change
- ☐ Payor Benefit

INSTRUCTIONS:
1. In performing the examination, bear in mind history in Part II.
2. Questions 3 and 4 need not be completed for age 10 years and below.

1. a. Name and address of Subject's personal physician? _____
(If none, so state)
b. Date and reason last consulted?_____
c. What treatment was given or medication prescribed?_____

2a. Height	Weight	Chest (Full inspiration)	Chest (forced expiration)	Abdomen at Umbilicus
_____cm. ___Ft. ___in.	_____kgs. _____ Lbs.	_____cm. _____in.	_____cm. _____in.	_____cm. _____in.

b. Did you weigh & measure subject? ☐ Yes ☐ No

(Please indicate below further details of your physical findings, including diagrams when necessary.)

3. BLOOD PRESSURE: (If above 135 systolic or 85 diastolic, report additional readings at 5 minute intervals)

	1st	2nd	3rd
SYSTOLIC			
DIASTOLIC			

4. PULSE: (If irregular, rate is over 90 or less than 60 per minute, perform EXERCISE TEST*)

	At Rest	After Exercise	3 minutes Later
RATE (per minute)			
IRREGULARITIES (per minute)			

*Ten full kneebends from standing position in one minute

5. HEART: Is there any a) Enlargement?_____ b) Murmur?_____ c) Arrhythmia?_____ d) Dyspnea?_____

(Give details and your impression below)

6. Is there on examination any abnormality of the following: (UNDERLINE APPLICABLE ITEMS AND GIVE DETAILS)

	CHECK BOX YES	NO
a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c) Nervous system (include reflexes, gait, paralysis?	☐	☐
d) Respiratory system?	☐	☐
e) Abdomen (including scars)?	☐	☐
f) Endocrine system (include thyroid and breast)?	☐	☐
g) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐

7. Is appearance unhealthy or older than age stated? ☐ ☐
8. Does subject smoke cigarettes? ☐ ☐
(IF "YES", HOW MANY DAILY?)

FULL NAME OF BANCASSURANCE SALES EXECUTIVE (BSE)

BSE'S CODE NO.	AMOUNT OF INSURANCE

9. How long have you known the Subject?

10. URINALYSIS:
(To be done by the Examiner in all cases)

ALBUMIN	TEST USED
SUGAR	TEST USED
SPECIFIC GRAVITY:	

☐ PLEASE CHECK BOX IF URINE WAS SECURED DURING MENSTRUAL PERIOD

SEND PART OF URINE SPECIMEN WITH PRESERVATIVE TO THE HOME OFFICE OR A COMPANY AUTHORIZED LABORATORY FOR MICROSCOPIC EXAMINATION IF:
1) AMOUNT OF INSURANCE IS AT LEAST P2,000,000 FOR AGES 11 & ABOVE
AMOUNT OF INSURANCE IS AT LEAST P1,000,000 FOR AGES 51 & ABOVE
AMOUNT OF INSURANCE IS AT LEAST P500,000 FOR AGES 61 & ABOVE
AMOUNT OF INSURANCE IS AT LEAST P100,000 FOR AGES 71 & ABOVE
2) SUGAR OR ALBUMIN IS PRESENT, OR
3) BLOOD PRESSURE IS OVER 140 SYSTOLIC OR 90 DIASTOLIC; OR
4) THERE IS HISTORY OR SUSPICION OF URINARY TRACT DISORDER, HYPERTENSION, OR DIABETES

URINE IS BEING SENT TO: (Check box & specify Lab)
☐ Manila Home Office
☐ Authorized Laboratory_____

I certify that I have carefully examined the person named above and that I personally asked each and every question in part II in the dialect/ language understood by the subject or legal guardian and recorded the answers thereon in my own handwriting. I further certify that the subject of examination and/or legal guardian signed this report in my presence.

THIS EXAMINATION WAS PERFORMED IN (PLACE): ☐ DOCTOR'S CLINIC
☐ APPLICANT'S RESIDENCE ☐ _____
ON (DATE) _____ AT (TIME) _____ AM/PM

If examination is for reinstatement of lapsed policy or policy change, please complete:

_____ Signature of Subject (or Legal Guardian)

_____ Date of Birth of Subject

_____ Signature of Medical Examiner

_____ Printed Name & Code of Medical Examiner

_____ Address of Medical Examiner

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MEDICAL FEE STUB (Do not detach)

Leave this portion blank

Name of Examiner (Pls. Print)	Code No.	MEDICAL REPORT NO.
Full Name of Applicant (Print)	Age / Date of Examination	FEE CREDITED - P
Your CODE NUMBER is the basis for the computerized monthly payment of fees by New Business Office. This medical form must be sent at once in a sealed envelope to New Business Office, 2nd Floor Philamlife Bldg, UN Ave., Ermita, Manila. Always advise New Business Office if you change your address.		DATE:
		COMPUTED BY: