



AUTHORIZATION TO FURNISH MEDICAL INFORMATION

Name of Applicant:	Reference No.:
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I/We hereby authorize any person, organization or entity that has any record or knowledge of my health and/or that of _____ to give to the BPI-Philam Life Assurance Corporation any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This is in connection with the application for insurance only. A photographic copy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____, 20 _____.

Name and Signature of Proposed Insured

Name and Signature of Proposed Owner

Witnessed by: _____
Name and Signature of Bancassurance Sales Executive
BSE Code: _____