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

HEALTH STATEMENT FORM

15th Floor Ayala Life - FGU Center, 6811 Ayala Avenue, Makati City

BSE 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 BPI-Philam 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

QUESTIONS	INSURED Yes	INSURED No	OWNER Yes	OWNER No
For Question 1, please explain a "NO" answer. For Questions 2-4, please explain a "YES" answer. Please use the space provided.				
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in plan or reinstatement of any insurance with our Company or other insurance companies which was declined, postponed, withdrawn, or modified in kind, amount or rate?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 BPI-Philam 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

BSE / Witness

PLEASE DO NOT SIGN ON A BLANK FORM.

Other Requests and Special Instructions

REMINDERS

REINSTATEMENT

Once the application for reinstatement is approved you will be required to pay your premiums plus interest and ant other applicalbe charges in order to put your policy back inforce.

TOP UP

Pay the top up amount only after the top up application has been approved.

GENERAL REQUIREMENTS

- Policyowner's Identification Cards
- Insured's Identification Cards if different from the Policy Owner
- Additional medical documents may be required in order for the company to reevaluate your insurability.

TO BE FILLED BY PHILAM LIFE PERSONNEL

If witnessed by a BSE, indicate if: ☐ Original ☐ Reinstating ☐ Assisting/Servicing/Transferred

BSE Signature ______

BSE Code: ☐☐☐☐☐☐☐☐☐☐

Received By ______ Date ______

Branch/Office ______

Processed By ______ Date ______

Branch/Office ______

Approved By ______ Date ______

Branch/Office ______

Documents submitted together with this application:

Notes: