Philippine Life
Financial Assurance Corporation
(Formerly AsianLife Financial Assurance Corporation)

HEALTH STATEMENT

Full Name of
Proposed Life Insured: _____ **Policy No.**_____
Last First Middle Name

Date of Birth: _____ **Age**: ____ **Place of Birth**: _____**Gender** :_____ **Height**: _____ (feet & inches) **Weight** : _____ (lbs)
Home Address: _____
Name of Employer/Company: _____ **Occupation** : _____
Company Address: _____
Contact Details: Residence: _____ **Office** :_____ **Cellphone**:_____ **Fax No.**: _____

Email Address: _____ **Amount of Insurance**: _____

Beneficiary/ies

Name	Age	Relationship
_____	____	_____
_____	____	_____
_____	____	_____

UNDERLINE APPLICABLE ITEMS	Checkbox Yes	Checkbox No
1. Are you presently in good health and entirely free from any mental or physical impairment or deformity?	☐	☐
If not, please give details. _____		
For Females: Are you pregnant?	☐	☐
If so, how many months? _____		
2. Have you gained or lost weight in the past 12 months?	☐	☐
If so, please give details: _____		
3. Have you been medically examined, received medical advice or treatment or been in the hospital?	☐	☐
If so, please give particulars including details of any X-rays, ECGs or other special tests performed: _____		
4. Are any surgical procedures being contemplated?	☐	☐
If so, please give details: _____		
5. Have you ever suffered from any of the following:		
a. epilepsy, fainting attacks or any disorder of the mental or nervous system?	☐	☐
b. asthma, bronchitis, pleurisy, pneumonia, tuberculosis or any other lung complaint?	☐	☐
c. chest pain, high blood pressure, palpitations, shortness of breath, stroke or any heart or circulatory trouble?	☐	☐
d. indigestion, gastric or duodenal ulcer, chronic or recurrent diarrhea or any complaint of the stomach or bowels?	☐	☐
e. diabetes or any disorder of the kidneys, liver, bladder or urinary system?	☐	☐
f. rheumatic fever, arthritis, gout or any bone or joint disease?	☐	☐
g. enlarged glands or any form of cancer, tumor or disorder of the blood?	☐	☐
h. unexplained recurrent or persistent fever, weight loss or any skin disorder?	☐	☐
i. any sexually transmitted disease (such as syphilis or gonorrhea) or have you ever sought medical advised treatment or a blood test in connection with a viral disease (such as hepatitis B or AIDS)?	☐	☐
j. any disease or disorder of the eyes, ears, nose, throat or mouth?	☐	☐
6. Are you presently taking medication of any kind?	☐	☐
7. Have you ever received treatment with any blood products or undergone a blood transfusion?	☐	☐
8. Except as prescribed by a physician, have you ever used shabu, cocaine, heroin, marijuana, LSD or other narcotics?	☐	☐
9. Have you ever been advised by a physician to stop drinking alcohol or to drink less?	☐	☐

Details of "YES" answers (Identify question by number and include dates, nature of complaints, duration, severity and results of treatment or tests done and names and addresses of all attending physicians and medical facilities.

I declare that all of the above answers and statements are true and correctly recorded and that no material facts concerning my past and present state of health and habits have been withheld or omitted.

I hereby authorize any physician, hospital, clinic, insurance company or any organization that has any record or information of me and my health to provide Philippine Life Financial Assurance Corp. any and all information about me and my medical history. A photocopy of this authorization shall be valid as the original.

Signed at _____ this _____ day of _____ 20_____.

_____	_____	_____
Signature over Printer Name of Witness	Signature of Applicant/Owner/Parent (If Proposed Life Insured is below 18 years old)	Signature of Proposed Life Insured

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