



VGP CENTER, 6772 AYALA AVENUE MAKATI CITY
 P.O BOX 1847, Contact Nos. 810-10-72 / 810-10-51 Fax# 813-36-47

HEALTH STATEMENT

INSURED NAME _____ POLICY NO. _____

DATE OF BIRTH _____ COMPANY NAME & OCCUPATION _____

NAME OF PAYOR/OWNER OR GUARDIAN _____ CONTACT NO. _____

DETAILS OF PAYMENT				Medically examined for this application? If "Yes", give Medical Examiner's name.	<input type="checkbox"/> Yes <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Date Examined						
DATE	BANK/APR/OPR DATE & NUMBER	AMOUNT									
Since your last medical examination, non-medical declaration or health statement made in connection with the above policy:				Please give full details of any 'YES' answers							
		<table border="1"> <tr> <th colspan="2">Insured</th> <th colspan="2">Payor</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Yes</th> <th>No</th> </tr> </table>				Insured		Payor		Yes	No
Insured		Payor									
Yes	No	Yes	No								
1. Have you consulted any doctor for medical treatment or has been confined in a hospital, clinic or similar institution? If so, when and what type of illness?											
2. Have you had any illness suffering from heart trouble, high blood pressure, cancer, diabetes, epilepsy tuberculosis, Acquired Immune Deficiency Syndrome (AIDS)?											
3. Have you made any application for insurance / rein- statement which was declined, postponed or modified?											
4. Have you changed your occupation or has there been any change in your avocation (e.g. racing, scuba or sky diving)?											
5. Do you plan to go or work abroad soon? When? Where? Purpose and nature of work?											
6. (For women only) Are you pregnant? If so, how many months?											

I / we hereby declare that each of the above representations is true and correct and that I / we have fully stated all details of each 'Yes' answer.

I / we agree that the issuance, amendment or reinstatement applied for shall not be considered effected by reason of any payment made by me / us unless this application is actually approved by the Company during my / our lifetime and good health and until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied.

I / we agree that any payment made in connection with this application shall be considered as deposit only and shall not bind the Company until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied and until this application is finally approved by the Company during my / our lifetime and good health. If this application is disapproved, I / we also agree to accept the refund of all payments made in connection therewith, without interest, and to surrender the receipts for such payments.

I / we further agree that the issuance, amendment or reinstatement of said Policy, as granted by the Company upon this application, shall be contestable at any time within two years from this date of approval thereof, for fraud or misrepresentation of any material facts therein stated.

"DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at <https://www.insurance.gov.ph>."

Signed at _____

On _____

**SIGNATURE OF WITNESS OVER
 PRINTED NAME**

SIGNATURE OF INSURED

DETAILS OF ID'S SUBMITTED BY INSURED/PAYOR

SIGNATURE OF OWNER / PAYOR

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CONSENT FORM
 (In Compliance with R.A. 10173)

I, _____, of legal age, Filipino citizen, and a resident of _____, do hereby state that: MANILA BANKERS LIFE INSURANCE CORPORATION, a corporation duly organized and existing under Philippine laws with office address at the 3rd Floor, VGP Center, Ayala Avenue, Makati City, is requesting for my personal data and information for the purpose of my application for life insurance coverage. I have been informed of my rights under R.A. 10173 otherwise known as the Data Privacy Act of 2012 and that I **fully understand my rights under R.A. 10173 and I hereby freely, voluntarily, willfully and intelligently give my consent to MANILA BANKERS LIFE INSURANCE CORPORATION to gather, collect, hold, process and use my personal data and information for the purpose stated above.**

 Data Subject/Applicant

