Policy Number/s

MUSCULOSKELETAL QUESTIONNAIRE - Applicant (To form part of the policy contract)

Name of Applicant: _____

1. State the precise diagnosis of your condition:

◯ Simple back pain ◯ Arthritis ◯ Herniated disc ◯ Sciatica
◯ Scoliosis ◯ Muscle weakness ◯ Spondylitis ◯ Osteoporosis
◯ Fracture ◯ Others: _____

2. When was this condition diagnosed? _____

3. Which particular body part is affected by this condition? _____

4. What is the underlying cause of this condition?

◯ Accident ◯ Degenerative ◯ Sports-related ◯ It runs in the family
◯ Unknown ◯ Others: _____

5. Has this condition restricted your physical activities in any way? ◯ YES, *provide details* ◯ NO

_____

6. Have you taken time-off work due to this condition? ◯ YES, *provide details* ◯ NO

_____

7. When did you last experience symptoms? _____

8. Have you had any investigation/test done regarding this condition?

◯ YES, *provide details or attach copy of results* ◯ NO

Date	Name of Test	Result
/ /	◯ X-ray	
/ /	◯ MRI Scan	
/ /	◯ CT Scan	
/ /	◯ Bone Scan	
/ /	◯ Arthroscopy	
/ /	◯ Ultrasound	
/ /	◯ Others:	

9. Where you prescribed any medication for this condition? ◯ YES, *please provide details* ◯ NO

Date Prescribed	Name of Medication	Dosage	Date Medication Stopped and Reason/s	
/ /			/ /	[Reason]
/ /			/ /	[Reason]
/ /			/ /	[Reason]

10. Please indicate all therapeutic procedures you have undergone related to this condition i.e. physical therapy, surgery, casting, etc.

Date of Procedure	Name of Procedure
/ /	
/ /	
/ /	

11. Have you been admitted to a hospital/facility due to this condition?

◯ YES, *please provide details* ◯ NO

Date Admitted	Date Discharged	Name of Hospital/Facility	Reason for Confinement
/ /	/ /		
/ /	/ /		

12. When was your last check-up with your doctor? _____

13. Please provide details of your attending physician.

Name of Attending Physician:
Specialization:
Contact Number:
Clinic Address:
Email Address:

DECLARATION

I confirm that the answers I have given are, to the best of my knowledge, true and correct and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I understand that the personal information collected or held by AXA Philippines may be used, stored, transferred (whether within or outside the Philippines) to such persons as AXA Philippines may consider necessary, including any of its affiliates or related companies, or any individuals/organizations/corporations/entities associated with AXA Philippines to process and deal with my application/policy to which this is appended to.

I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate my insurance. Furthermore, I understand that declaration of any untruthful statement may also be a ground to invalidate my insurance.

_____ _____

Name and Signature Date of Signing

AXA PHILIPPINES

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