Health Statement Form (for Rider Addition)

Important Notes:
1. This form is to be accomplished by the Policy Owner/Assignee in BLOCK LETTERS.
2. Please do not sign on a blank form.
3. Please put a shade in the circle to indicate your choice(s).

1. My General Information (MANDATORY SECTION. Please complete all fields.)

**Full Name of Insured (Last Name, First Name, Middle Initial)**

**Full Name of Policy Owner (Last Name, First Name, Middle Initial)**

**Policy updates via:**  □ E-mail  □ SMS Notification

**My current mobile no.**  ___________________________  (09XX-XXXXXXXX)

**My e-mail address**

**My other telephone nos.**

2. Rider to be added and Health & Avocation Information

**VARIANT**

For secure rider, please answer questions 1-3

□ Secure - accidental death and dismemberment benefit

□ Critical Conditions - critical illnesses benefit

□ Care - daily hospitalization benefit

□ Protector - additional life insurance coverage

□ Health Max Rider - guaranteed health coverage for 56 major & 18 minor critical illnesses

□ Waiver of premium - waives all future premiums in case of total and permanent disability of insured

□ Payor’s clause - waives all future premiums in case of total and permanent disability or death of payor

Please state the height and weight of the Proposed Insured/Owner.

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>________ ft/in  ________ lbs</td>
</tr>
<tr>
<td>Policy owner</td>
<td>________ ft/in  ________ lbs</td>
</tr>
</tbody>
</table>

Have you experienced any weight change in the last 12 months, please state amount gained or lost (lbs.) and the reason for weight change.

QUESTIONS

1. Have you ever applied for life, health, critical illness cover, accident or disability insurance that has been declined, postponed, rated, modified or renewal refused? Or received any claims benefit from existing cover? If yes, please provide details.

<table>
<thead>
<tr>
<th>Insured</th>
<th>Owner (Please state Payor if clause is applied for)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

2. Are you exposed to any danger in the pursuance of your occupation or do you intend to engage in any of the following pursuits?
   - Any dangerous sports/activities (e.g. Aviation, Skydiving, parachuting, hang gliding, motor sports, diving, climbing, caving, or scuba diving below 45 meters)

   □ Yes  □ No

3. Since the original policy inception date, has your occupation changed?
   If yes, please state new occupation and duties.
   Have you ever held or intend to be a candidate, in the coming election, in public elective office? Please indicate position.

   □ Yes  □ No  □ Yes  □ No  □ Yes  □ No  □ Yes  □ No
### Health Statement Form

#### QUESTIONS

<table>
<thead>
<tr>
<th>Insured</th>
<th>Owner (if applicable)</th>
<th>If “yes”, please indicate details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

4. **Do you smoke cigarettes/cigars or consume any other form of tobacco (including smokeless tobacco)?**
   - Yes
   - No
   - If yes, indicate no. of cigarettes or tobacco sticks/day and no. of years smoking:
   - No. of cigarettes/tobacco per day: __________
   - No. of years smoking: __________

5. **Are you currently receiving any medical treatment or do you intend seeking or have been advised to seek medical treatment for any health problem or are you waiting for the results of any tests/investigations?**
   - Yes
   - No
   - If illness is not stated below, kindly specify the details.
   - Chest pain, high blood pressure, heart attack, stroke, diabetes, any heart, blood disorders or vascular diseases
   - Cancer, melanoma, tumour/lump/polyps/growth of any kind.
   - Gastrointestinal, genitourinary, respiratory, ears, eyes, epilepsy, neurological, psychiatric, kidney, liver, metabolic and endocrine disorders
   - Joint, limb or bone conditions, autoimmune diseases, infectious diseases
   - Hepatitis B or C, HIV, tuberculosis, alcohol or drug dependency
   - Unexplained weight loss
   - Have you ever seen a Doctor or other health professional, or been prescribed medication for any other condition which has lasted for more than 5 days (apart from usual flu and colds).

6. **Has your biological mother, father, or any sister or brother been diagnosed prior to age 60 with any inherited conditions (e.g. Cancer, Heart Attack, Stroke, Huntington’s disease, Polycystic Kidney Disease)?**
   - Yes
   - No

7. **For Female Applicant Only**
   - Are you currently pregnant?
   - Yes
   - No
   - Please indicate if with pregnancy related complications.

### 3. Declarations and Agreement

I agree that the approval of this application is based on the truth of the above statements.

I also agree that any payment made or to be made by me in connection with the application shall be considered as deposit only and shall not bind AXA Philippines in any manner until the application is finally approved during my or the insured’s lifetime and good health. I also understood that if this application is finally disapproved, AXA Philippines will refund any deposit without interest.

**IMPORTANT: PLEASE DO NOT SIGN ON A BLANK FORM**

Signed at __________________________ this ________ day of ____________________

**Signature of Insured**

**Signature of Policy Owner**

### 4. Certification of Customary Signature

**IMPORTANT: If signature differs between AXA file and documents submitted, please complete this form.**

**CERTIFICATION OF CUSTOMARY SIGNATURE**

This is to certify that I am the same person who signed in the policy contract. I hereby confirm that the declarations and information therein were given by me, and I certify that they are true and complete to the best of my knowledge. Finally, the signature appearing on all the forms and valid ID/s are my customary signatures and for which reason I have signed both with my customary signatures as follows:

1. 
2. 
3. 

### 5. How do I track the status of my request

You will be updated through SMS &/or e-mail (if you choose e-notiXes) of additional requirements, if any. If you have any query on your request, you may get in touch with your AXA distributor or reach us by:

- **+632 8-5815-AXA**
- **customer.service@axa.com.ph**
- **Chat via www.axa.com.ph**

AXA is committed to making your service experience as easy and stress-free as possible. Thank you for insuring with us. We are always glad to be of service.