Policy Number(s) ___ – _______

Health Statement Form

FOR OFFICE USE ONLY
Date Received: ___________
Time Received: ___________
Receiving Dept./Office: ___________

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).

FOR DISTRIBUTOR'S USE ONLY
FE/Advisor's code: ________________________
FE/Advisor's name: ________________________
FE/Advisor's mobile number: ________________________

○ With payment Payment Center ________________________
Date ____________________
Amount ________________
○ Without payment

1. Type of Request

○ Reinstatement	○ Inflation Index (IIE) Activation	○ Top-Up Regular ____________________
○ Increased Sum Insured	○ Removal of Temporary Loading	○ Top-Up Lump Sum__________________

2. 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-XXXXXXX)**

My e-mail address

My other telephone nos. Residence ________ Office ________

3. Health & Avocation Information

		Height	Weight	Have you experienced any weight change in the last 12 months, please state amount gained or lost (lbs.) and the reason for weight change.
Please state the height and weight of the Proposed Insured/Owner.	Insured	__________ ft/in	__________ lbs	
	Policy owner	__________ ft/in	__________ lbs	

	QUESTIONS	Insured Yes	Insured No	Owner (Owner to answer if payor's clause is applied for) Yes	Owner No	If "yes", please indicate details
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.	○	○	○	○	
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)	○	○	○	○	
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.	○	○	○	○	
4.	Do you smoke cigarettes/cigars or consume any other form of tobacco (including smokeless tobacco)? (If yes, indicate no. of cigarette or tobacco sticks/day and no. of years smoking)	○	○	○	○	No. of cigarettes/tobacco per day: __________ No. of years smoking: _____________

	QUESTIONS	Insured Yes	Insured No	Owner (Owner to answer if payor's clause is applied for) Yes	Owner No	If "yes", please indicate details
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? 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, auto immune 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)?	◯	◯	◯	◯	
7.	For Female Applicant Only • Are you currently pregnant? • Please indicate if with pregnancy related complications.	◯	◯	◯	◯	No. of Months: ______________ Expected delivery date: ______________ Complications: ________________________ ____________________________________

4. Declarations and Agreement

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

I also agree that if any of the statements above is found to be untrue in any respect and the policy has not been in force during the insured's lifetime for at least two (2) years from the approval date of this application, AXA Philippines shall have the right to declare such request as null and void.

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

5. 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.

6. 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.