



redefining / standards



Policy Number(s)

Grid for Policy Number(s)

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)

Grid for Full Name of Insured

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

Grid for Full Name of Policy Owner

Policy updates via: E-mail SMS Notification

My current mobile no. [Grid] - [Grid] (09XX-XXXXXXX)

My e-mail address [Grid]

Residence [Grid] Office [Grid]

My other telephone nos. [Grid]

FOR OFFICE USE ONLY

Date Received: _____
Time Received: _____
Receiving Dept./Office: _____

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

2. Rider to be added and Health & Avocation Information

VARIANT

For secure rider, please answer questions 1-3

Secure - accidental death and dismemberment benefit YRT 20YRT UP TO AGE 55 5 PAY 10 PAY

For the following riders, please answer questions 1-7

Critical Conditions - critical illnesses benefit YRT 20YRT UP TO AGE 55

Care - daily hospitalization benefit YRT Economy Regular Superior Premier 20YRT UP TO AGE 55 Economy Premier Superior

Protector - additional life insurance coverage YRT 5YRT 10YRT 20YRT 5 PAY 10 PAY 20 PAY UP TO AGE 55 5 PAY 10 PAY 20 PAY UP TO AGE 55

Health Max Rider - guaranteed health coverage for 56 major & 18 minor critical illnesses 20 PAY PAY TO AGE 65

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

		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

	QUESTIONS	Insured		Owner <small>(Owner to answer if payor's clause is applied for)</small>		If "yes", please indicate details
		Yes	No	Yes	No	
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Health Statement Form

QUESTIONS	Insured		Owner <small>(Owner to answer if payor's clause is applied for)</small>		If "yes", please indicate details
	Yes	No	Yes	No	
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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? If illness is not stated below, kindly specify the details. <ul style="list-style-type: none"> 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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
7. For Female Applicant Only <ul style="list-style-type: none"> Are you currently pregnant? Please indicate if with pregnancy related complications. 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No. of Months: _____ Expected delivery date: _____ 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 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**

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 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.