Policy Number(s)

Health Statement Form

Important Notes:
1. This form is to be accomplished and signed by the Policy Insured/Policy Owner in **BLOCK LETTERS**. In case the Insured is under 18 years old, the legal guardian should provide the Insured's details and sign this form.
2. Prepare the relevant documents listed in Section 1 and submit them to your Financial Advisor or the nearest AXA branch.
3. All fields are mandatory unless stated otherwise.
4. **Do not sign on a blank form.**

1. Requirements

BASIC REQUIREMENT

- ◯ **Completed Health Statement Form**
- ◯ **Valid ID of the Policy Owner and/or Policy Insured**
  - Actual IDs must be presented and photocopies submitted
  - At least one (1) must be government-issued and shows date of birth, signature, and photo

CONDITIONAL REQUIREMENTS *(Submit additional requirements appropriate to your case)*

For Lump Sum or Regular Top-Up

◯ Completed Variable Life Policy Lump Sum or Regular Top-Up Application Form

For Increase of Sum Insured/Rider Coverage, Change in Loading/Rating, or Addition of Rider

◯ Completed Policy Change Request Form

Note: The Company reserves the right to ask for additional documents as deemed necessary.

FOR OFFICE USE ONLY

This serves as an acknowledgement receipt and initial advice of the requirements if initialized.

Date Received: _____

Time Received: _____

Receiving Dept./Office: _____

FOR WITNESS ONLY

This section is to be accomplished by the AXA Representative who validated the identity of customer and authenticated the documents received.

Full Name: _____

Designation/Branch: _____

Date and Signature: _____

2. Type of Request

◯ **Reinstatement** ◯ **Increase of Sum Insured/Rider Coverage** ◯ **Addition of Rider**
◯ **Lump Sum Top-Up** ◯ **Declaration of Medical Condition**
◯ **Regular Top-Up** ◯ **Change in Loading/Rating**

3. Principal Insured's Details

These fields are required. Please do not leave them blank.

Full Name of Principal Insured

Last Name | *First Name* | *Middle Name*

Is the Principal Insured a US citizen or US tax resident? ◯ Yes ◯ No

If yes, please provide the details below:

US TIN/SSN ___ - __ - ____

Is the Principal Insured or their immediate family/close associate a Politically Exposed Person (PEP)? ◯ Yes ◯ No

A PEP is a person who currently or previously holds a high-ranking public position in a) the Philippines, b) a foreign country, or c) an international organization. This includes roles with significant authority over public policies, operations, or use of public resources.

If yes, please indicate the PEP's position/public office below:

The section below is optional. If you need to update your personal information or contact details, please fill out only the specific fields that require changes.

Primary Occupation | **Secondary Occupation**

Sources of Funds
Refers to the source(s) of the Principal Insured's funds that will be used for transactions with AXA Philippines. Leave blank if there is a different Policy Owner.

◯ Maturing Investments (PHP _____) ◯ Savings (PHP _____) ◯ Others: _____ (PHP _____)

Sources of Wealth
Refers to the source(s) of the Principal Insured's total wealth, regardless of whether any part of it will be used to transact with AXA Philippines.

◯ Salary (PHP _____/month) ◯ Business Income (PHP _____/month) ◯ Others: _____ (PHP _____/month)

Sex
◯ Male ◯ Female

Date of Birth (MM/DD/YYYY)

Place of Birth

Nationality

Residence/Present Address
Unit/Floor Number, Building Name, Street, Barangay, City, and Province

Personal Email Address

Mobile No.

Home Phone No. (Optional)

Note: The email address must be active.

4. Co-Insured's Details (applicable for Joint Life Policy ONLY)

These fields are required. Please do not leave them blank.

Full Name of Co-Insured

Last Name | *First Name* | *Middle Name*

Is the Co-Insured a US citizen or US tax resident? ◯ Yes ◯ No

If yes, please provide the details below:

US TIN/SSN ☐☐☐ - ☐☐ - ☐☐☐☐

Is the Co-Insured or their immediate family/close associate a Politically Exposed Person (PEP)? ◯ Yes ◯ No

A PEP is a person who currently or previously holds a high-ranking public position in a) the Philippines, b) a foreign country, or c) an international organization. This includes roles with significant authority over public policies, operations, or use of public resources.

If yes, please indicate the PEP's position/public office below:

The section below is optional. If you need to update your personal information or contact details, please fill out only the specific fields that require changes.

Primary Occupation

Secondary Occupation

Sources of Funds
Refers to the source(s) of the Co-Insured's funds that will be used for transactions with AXA Philippines. Leave blank if there is a different Policy Owner.

◯ Maturing Investments (PHP _____) ◯ Savings (PHP _____) ◯ Others: _____ (PHP _____)

Sources of Wealth
Refers to the source(s) of the Co-Insured's total wealth, regardless of whether any part of it will be used to transact with AXA Philippines.

◯ Salary (PHP _____/month) ◯ Business Income (PHP _____/month) ◯ Others: _____ (PHP _____/month)

Sex
◯ Male ◯ Female

Date of Birth (MM/DD/YYYY)

Place of Birth

Nationality

Residence/Present Address
Unit/Floor Number, Building Name, Street, Barangay, City, and Province

Personal Email Address | **Mobile No.** | **Home Phone No. (Optional)**

Note: The email address must be active.

2. Policy Owner's Details (to be filled out ONLY if different from the Policy Insured)

These fields are required. Please do not leave them blank.

Full Name of Policy Owner

Last Name | *First Name* | *Middle Name*

Is the Policy Owner a US citizen or US tax resident? ◯ Yes ◯ No

If yes, please provide the details below:

US TIN/SSN ☐☐☐ - ☐☐ - ☐☐☐☐

Is the Policy Owner or their immediate family/close associate a Politically Exposed Person (PEP)? ◯ Yes ◯ No

A PEP is a person who currently or previously holds a high-ranking public position in a) the Philippines, b) a foreign country, or c) an international organization. This includes roles with significant authority over public policies, operations, or use of public resources.

If yes, please indicate the PEP's position/public office below:

The section below is optional. If you need to update your personal information or contact details, please fill out only the specific fields that require changes.

Primary Occupation | **Secondary Occupation**

Sources of Funds

Refers to the source(s) of the Policy Owner's funds that will be used for transactions with AXA Philippines.

◯ Maturing Investments (PHP _____) ◯ Savings (PHP _____) ◯ Others: _____ (PHP _____)

Sources of Wealth

Refers to the source(s) of the Policy Owner's total wealth, regardless of whether any part of it will be used to transact with AXA Philippines.

◯ Salary (PHP _____/month) ◯ Business Income (PHP _____/month) ◯ Others: _____ (PHP _____/month)

Sex | **Date of Birth (MM/DD/YYYY)** | **Place of Birth** | **Nationality**

◯ Male ◯ Female

Residence/Present Address

Unit/Floor Number, Building Name, Street, Barangay, City, and Province

6. Rider Variants (applicable for Addition of Rider ONLY)

	VARIANT			
◯ **Secure**	◯ YRT	◯ 20 YRT ◯ 5-Pay ◯ 10-Pay	◯ Up to age 55 ◯ 5-Pay ◯ 10-Pay	
◯ **Critical Condition**	◯ YRT	◯ 20 YRT ◯ Up to age 55	◯ Critical Shield Rider	
◯ **Care**	◯ YRT	◯ Economy ◯ Superior ◯ Regular ◯ Premier	◯ 20 YRT ◯ Up to age 55	◯ Economy ◯ Superior ◯ Premier
◯ **Protector**	◯ YRT ◯ 5 YRT ◯ 10 YRT	◯ 20 YRT ◯ 5-Pay ◯ 20-Pay ◯ 10-Pay	◯ Up to age 55 ◯ 5-Pay ◯ 20-Pay ◯ 10-Pay	
◯ **Bright Rider Plus**	◯ 12 YRT ◯ 13 YRT	◯ 14 YRT ◯ 15 YRT	◯ 16 YRT ◯ 17 YRT	◯ 18 YRT ◯ 19 YRT ◯ 20 YRT ◯ 21 YRT ◯ 22 YRT
◯ **Health Max Rider**	◯ 20-Pay	◯ Up to age 65		

◯ **Waiver of Premium**	
◯ **Payor's Clause**	
◯ **Others** *please provide the details*	
	**YRT - Yearly Renewable Term*

7. Additional Information of Insured and Owner

	Height	Weight	Have you experienced any weight change in the last 12 months? Please state the amount lost (lbs.) and reason for weight change.
Policy Owner	ft/in	lbs	
Principal Insured	ft/in	lbs	
Co-Insured	ft/in	lbs	

	Medical Questions	Principal Insured	Co-Insured	Policy Owner *to answer if Payor's Clause is applied for*	*If you answered **YES**, please provide the details below*
1.	Do you have any family members who have been diagnosed before age 60 with any of the following: cancer, heart attack, stroke, diabetes, Huntington's disease, or any other inherited conditions?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
2.	Have you been diagnosed with, or previously manifested any signs or symptoms of, or are currently receiving any medical treatment for, or intend to seek or have been advised to seek medical treatment for any health problems listed below:				
	a) Chest pain, high blood pressure, heart attack, stroke, diabetes, elevated cholesterol, or any heart/blood/vascular diseases	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	b) Cancer, mass, tumor, lump, polyp, cyst, or growth of any kind	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	c) Gastrointestinal, genitourinary, respiratory, ears, eyes, neurological, psychiatric, kidney, liver, metabolic, and endocrine disorders	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	d) Joint, limb, or bone conditions, auto-immune, and infectious diseases	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	e) Hepatitis B or C, HIV, tuberculosis, alcohol, or drug dependency	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	If the illness is not mentioned above, please provide the details on the farthest right side.				
3.	Are you waiting for the results of any tests or investigations for the above-mentioned medical conditions? *If the illness is not stated above, please provide the details on the farthest right side.*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
4.	Have you ever been prescribed medication for any condition that lasted more than five days, excluding usual flu and colds?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
5.	**FOR WOMEN APPLICANTS ONLY** Are you currently pregnant? *If you answered YES, please provide the details on the farthest right side.*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	**How many months?** **Expected Delivery Date:** **Complications, if any:**
	Other Insurance, Occupation, and Lifestyle Information				
6.	Have you ever had an application for Life, Critical Illness, Accident, Medical, or Disability insurance that was				
	a) modified, rated, or offered with a reduced face amount, declined, or postponed; or	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
	b) rejected for reinstatement or renewal due to health/medical reasons?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	

7.	Have you made or received any claim benefits on any policies or other accounts?	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
8.	Since the issuance of the policy, have you or any insured persons changed occupation? *If there has been a change in occupation, please provide the new occupation and duties on the farthest right side.*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
9.	Have you ever held or do you intend to be a candidate in the upcoming election for a public elective office? *If you answered YES, please indicate the position on the farthest right side.*	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
10.	Do you participate in or intend to participate in any hazardous activities related to your occupation or recreational activities such as (but not limited to): a) scuba diving b) mountaineering or climbing c) skydiving d) parachuting e) hang-gliding f) motor sports; or g) aviation (excluding flying as a passenger on a regularly scheduled airline)	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	
11.	Have you smoked or used any of the following in the past twelve months? a) Cigarettes b) E-cigarettes c) Vaping products d) Smokeless tobacco d) Never smoked	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	

		PI	CI	PO
No. of	Sticks/day			
	Packets/day			
	Months/Years			
ml per day (if vaping)				

PI - Principal Insured
CI - Co-Insured
PO - Policy Owner

If you answered YES to any of the above questions, attach supporting documents such as physical analysis, laboratory results, and other medical records to this form as appropriate.

9. Certification of Customary Signature (MANDATORY SECTION)

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 forms and valid ID(s) submitted herewith are my customary signatures and for which reason I have signed both with my customary signatures as follows:

1.	2.	3.

10. Declarations and Agreement

I hereby declare and agree that:

1. The application as indicated above is based on my own judgment and I did not rely on any advice provided by the Financial Advisor.
2. All information in the application, to the best of my knowledge and belief, is complete and true.
3. Any personal data of the Relevant Persons (Principal Insured, Co-Insured, Policy Owner) collected or held by AXA Philippines, whether contained in the application or otherwise, may be utilized, stored, disclosed, transferred (whether within or outside the Philippines) to individuals, organizations, corporations, or entities as AXA Philippines may consider necessary, including but not limited to any of its affiliated or related companies, within or outside the Philippines:
   a. to process and deal with the application;
   b. to provide all services related to the application and promote and improve services by the Company and its affiliated companies;
   c. to communicate with me for any purpose and/or to comply with the laws of any applicable jurisdiction including but not limited to Insurance Commission rules and regulations, the Anti-Money Laundering Act, and the Data Privacy Act.
4. If the Relevant Persons fail to provide any information requested in the application, it may result in the Company's inability to process and to deal with the application.
5. I have the right to access my personal information at any time; correct or rectify any information collected or held by AXA Philippines which are inaccurate, false, or incomplete; object in case of any unauthorized collection; erase or block informa-

tion which is incomplete, outdated, or false; and such other rights as may be available under the Data Privacy Act. Such requests must be made in writing and submitted to AXA Philippines.

6. Should any statements be incomplete, false, wrong, or inaccurate, or any omissions on my part in disclosing the information, the Company shall have the right to cancel the Policy, repudiate the claim, and forfeit all payments received.

7. The Company is not bound by any statement I may have made to any person if not written or printed here.

8. The request for reinstatement, change, or addition requires evidence of insurability that consists of this application and health declaration and shall not take effect unless all of the following conditions are met:
   a. Any required payment for the application is paid in full;
   b. The application is approved by AXA Philippines during the lifetime and continued insurability of the person or persons insured by the policy.

9. The request for change, which does not require evidence of insurability, shall consist of this application and shall be effective from the date of this request unless a letter date is specifically indicated, but only if the change is provided by the policy or is allowed by AXA Philippines under the policy.

10. The Incontestability Provision and Suicide Exclusion Provision in the policy shall apply upon reinstatement, changes, or addition of sum insured or supplements, and the period of time specified in the said provisions shall run from the date of approval of this application by AXA Philippines.

11. This form and the evidence of insurability of the person or persons insured, if required by AXA Philippines, shall be the basis for the change in this policy and form part of the policy unless otherwise specified.

12. My policy contract, notices, and communications related to my policy may be sent to me via mail, email, or SMS using the contact details I have provided above. I understand that I may contact AXA to update, specify, or change my preferred mode of receiving notices to receiving a hard copy at my registered address instead of via email.

13. Before signing this declarations and agreements, I have read and understood all declarations and agreements which are hereby given and made willingly and voluntarily and with full knowledge of my rights under the law.

11. Privacy Policy

Your privacy is a priority for AXA Philippines. To understand more on how we use and protect your personal data, you may refer to our Privacy Policy at https://www.axa.com.ph/privacy-policy.

12. Acknowledgement and Signature

By signing this form, I/we acknowledge that above declarations have been thoroughly discussed with me and explained to me by the AXA Financial Advisor.

◯ I/We consent to receive notices and announcements for marketing and/or cross selling purposes via Short Messaging Services (SMS), email, other electronic platform, or telephone call from AXA Philippines, its affiliates, subsidiaries, including any person or entities providing services on AXA's behalf.

IMPORTANT: PLEASE DO NOT SIGN ON A BLANK FORM AND ENSURE YOUR SIGNATURE STAYS WITHIN THE BOX.

Signed at _____ this _____day of _____.
Place of Signing *Day* *Month / Year*

Name of Policy Owner

Signature of Policy Owner

Name of Principal Insured (if minor, Legal Guardian)

Signature of Principal Insured / Legal Guardian

Name of Co-Insured (if minor, Legal Guardian)

Signature of Co-Insured / Legal Guardian

How do I track the status of my request?

You will be updated through email.
If you have any query on your request, you may get in touch with us through

Your AXA Financial Advisor

Live chat at https://www.axa.com.ph/contact-us

Your nearest AXA branch

You may also access your policy information and conveniently conduct online transactions through the Emma by AXA PH app or via web at https://www.axa.com.ph/emma.

Thank you for choosing AXA, a global leader in insurance and investment, and your partner in protecting what matters.