Fortune LIFE
Securing your tomorrow today

FORTUNE LIFE INSURANCE CO., INC.
Fortune Life Building, 162 Legazpi Street,
Legazpi Village, 1229 Makati City
Tel. Nos.: 892 9841 to 49 (connecting all departments)
Fax Nos.: 813 7339
E-mail Address: fortlife@fortunelife.com
URL: http://www.fortunelife.com

HEALTH STATEMENT FORM

FORTUNE LIFE INSURANCE CO., INC. is hereby requested by the undersigned to put POLICY NUMBER ______________________ **in force.**

PLEASE ANSWER EACH QUESTION BELOW FOR:
INDIVIDUAL POLICY - Insured portion only must be accomplished.
CHILD'S POLICY - Insured and Owner/Payor portion must be accomplished.

If answer is "YES" details such as full name; nature and duration of illness; dates; physicians' names; addresses, other companies: etc., must be indicated below this portion.

	INSURED		PAYOR		DETAILS
	YES	NO	YES	NO	
Has any one, since the date of this policy:					
1. Consulted or been treated by any Physician or licensed person?	☐	☐	☐	☐	1.
2. Had any physical impairment, sickness, operation, mental disorder, injury?	☐	☐	☐	☐	2.
a. Had any complications of pregnancy?	☐	☐	☐	☐	
b. Is she pregnant?	☐	☐	☐	☐	
3. Changed in weight? (If yes, give amount; cause, present weight. Disregard child's normal growth).	☐	☐	☐	☐	3.
4. Applied for new or reinstated insurance or become covered under the Medicare programs, a hospital or surgical service plan or similar insurance? (If yes, give details-companies; amounts; types of insurance; whether pending, issued, refused, postponed, limited)	☐	☐	☐	☐	4.
5. Changed occupation? (If yes, give all occupations - employers, types of industry, all duties.) Average monthly earnings? P _________	☐	☐	☐	☐	5.
6. Engaged in aviation activities or hazardous sports, avocations, hobbies; or expect to do so?	☐	☐	☐	☐	6.

I/WE HEREBY DECLARE AND AGREE THAT:

1. Each of the foregoing statements is true and correct and that I/We have fully stated all details of "YES" answers to any of the above questions.

2. If, at any time within two (2) years from the date of the approval hereof, any statements herein made shall be found to be untrue in any respect the Company shall have the right to declare null and void and of no effect the reinstatement of said Policy as granted by the Company upon this application.

3. Said policy shall not be considered reinstated until this application shall be approved by the Company at its Home Office during my lifetime and good health, subject to the conditions herein set forth, and that any payment of premiums made by me in advance, or any receipt thereof, shall not be binding upon the Company until this, application is approved during my lifetime and good health, and subject to said conditions. If said Policy is not reinstated, I agree to accept, the return of all advance payments made in connection with this application, without interest; and to surrender the receipt received for such sums.

4. Fortune Life is authorized to make available to the Medical Information Bureau (MIB) of the Philippines any information regarding my health and other aspects relating to my insurability, as revealed in the course of this application for insurance.

5. I authorize any physician, hospital, clinic, insurance company, or other organization, or entity, institution, or person that has any records, or knowledge of me, to give Fortune Life or its representative any information with reference to health, hospitalization, consultation, advice, examination, treatment, disease, or ailment. A photostatic copy of this authorization shall be as effective and as valid as the original.

Done at ____________________________________ this ________________ day of ________________________ 20 _______.

____
Witness (Print Name & Sign Above)

____
Address of Witness

____
Applicant (Print Name & Sign Above)

____
Reinstating Agent (Print Name & Sign Above)

____
Applicant-Owner/Payor (Print Name & Sign Above)
(If insured is below 18 years old)

____
Agent's Code Number

PHILIPPINE LIFE INSURANCE ASSOCIATION, INC.
MEMBER