FWD insurance

Celebrate living
fwd.com.ph

# Health Statement Form

Policy Number | | | | | | | | | |  FWP/FSC Code | | | | | | | | |

Please fill in block letters and tick appropriate boxes and circles. Requests received by FWD service counters within the cut-off time of 2:00 PM will be processed within the day. Requests received beyond cut-off time will be processed the next business day.

## 1. Personal Data of Policy Owner (Your personal information in our database shall be updated based on the details you provide below.)

Name of Policy Owner

| Title | First Name | Middle Name | Last Name | Ext Name |
|---|---|---|---|---|
| | | | | |

| Date of Birth (mm/dd/yyyy) | Place of Birth | Country of Birth | Nationality |
|---|---|---|---|
| | | | |

## 2. Service Request/s

- ☐ Straight Reinstatement
- ☐ Redate Reinstatement
- ☐ Remove / Change Rating _____
- ☐ Change Plan To _____
- ☐ Add Rider _____
- ☐ Adhoc Top-Up _____
- ☐ Increase In Sum Assured _____
- ☐ Other Transaction _____

If request is for Reinstatement, please provide complete information below:

Name of Policy Owner

| Title | First Name | Middle Name | Last Name | Ext Name |
|---|---|---|---|---|
| | | | | |

| Date of Birth (mm/dd/yyyy) | Place of Birth | Country of Birth |
|---|---|---|
| | | |

| Email Address: | Nationality |
|---|---|
| | |

| ID Type | ID Number | Expiry Date | TIN/SSS/GSIS No. |
|---|---|---|---|
| | | | |

Current Residence Address

| No. and Street | Barangay/Subdivision | |
|---|---|---|
| | | |
| Municipality,Town/City | Province/Country | Zip Code |
| | | |
| Contact Information (Country Code) (Area Code) (Telephone/Mobile Number): | | |

Permanent Address

| No. and Street | Barangay/Subdivision | |
|---|---|---|
| | | |
| Municipality,Town/City | Province/Country | Zip Code |
| | | |
| Contact Information (Country Code) (Area Code) (Telephone/Mobile Number): | | |

Business/Office Address

| No. and Street | Barangay/Subdivision | |
|---|---|---|
| | | |
| Municipality,Town/City | Province/Country | Zip Code |
| | | |
| Contact Information (Country Code) (Area Code) (Telephone/Mobile Number): | | |

## 3. U.S. Tax Declarations

1. Are you a citizen, taxpayer, passport holder or green card holder of the U.S. or were born in the U.S.? ○ Yes ○ No

If yes, please provide a copy of your IRS W-Form and the below information:
- U.S. I.D. / Passport no. / Green Card No.
- U.S. Tax Identification Number / Social Security Number
- U.S. Permanent residence address

2. For Corporate Accounts only:
Do you have a beneficial ownership holding 10% or more or any (direct or indirect) interest by a U.S. citizen, taxpayer, resident or entity? ○ Yes ○ No

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## 4. Health Statement

| Declaration | Owner | | Insured | | Explanation/Details |
|---|---|---|---|---|---|
| Please use the space provided to explain a "YES" answer. | Yes | No | Yes | No | Indicate Diagnosis, Date of Diagnosis, Name and Address of Attending Physician, Medicine and Test Result. |
| 1) Have you suffered from, have been treated for, or have any indication of: chest pain, heart attack, high blood pressure, stroke, cancer growth/tumor, diabetes, hepatitis, any disorder of the heart, lung, liver, kidney, spine, joints, digestive system, any mental or nervous disorder, alcoholism, drug abuse, HIV or AIDS related complications, any physical defects or deformities? Have you consulted a specialist and/or have ever been hospitalized and/or undergone any surgical operation and/or ever had a diagnostic test with an abnormal result and/or ever been advised to have any of these in the future? | ○ | ○ | ○ | ○ | |
| 2) Are you engaged in any hazardous pursuit or occupation, e.g., aviation, scuba diving, sky diving, motor sports, hang gliding, etc.? | ○ | ○ | ○ | ○ | |
| 3) Do you have any immediate family member who was diagnosed with diabetes, heart problem, stroke, high blood pressure, kidney disease, cancer or other hereditary disease before age 65? | ○ | ○ | ○ | ○ | |
| 4) Do you have, or ever had, an application for insurance that has been declined, postponed, rated, accepted on special items, or has been rescinded due to material misrepresentation and/or concealment? | ○ | ○ | ○ | ○ | |
| 5) Are you pregnant? (For female applicants only) If pregnant, indicate age of gestation. | ○ | ○ | ○ | ○ | |

## 5. Data Protection

FWD has appointed a Data Protection Officer to handle any inquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Corporation Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 19/F, W Fifth Avenue Bldg., 5th Avenue cor. 32nd Street, Bonifacio Global City, Taguig City 1634, Philippines.

## 6. Declaration

**I UNDERSTAND AND CONFIRM THAT:**

1. The information I have provided above and in any supporting documents and/or records (collectively defined as this 'Form') are true and complete and shall form part and be the basis of the assessment of this request and approval. I understand that providing false, inaccurate or incomplete information may result in my transaction request being denied and shall give FWD the right to cancel the Policy, repudiate the claim or forfeit all payments to be made.
2. I understand that my request (if applicable) for policy change, reinstatement, or addition of coverage/rider which requires evidence of insurability shall not take effect unless duly approved by FWD and any required payment for the transaction request is paid in full. I further understand that the Incontestability and Suicide Exclusion provisions in the Policy shall apply and the period stated thereunder shall run upon FWD's approval of the request for reinstatement, increase or decrease of sum insured or rider.
3. I have fully disclosed all of my citizenships, tax status, residencies, relevant taxpayer identification numbers and agree to notify FWD within thirty (30) days of any changes to the above information. For the purposes of ensuring continued compliance, FWD may request information and/or documents from me including completed, executed and, if necessary, notarized tax declarations or forms.
4. I authorize FWD to disclose my personal and financial information to any government or tax authority (within or outside the Philippines) for the purposes of ensuring FWD's continual compliance with applicable laws, regulations, guidelines and good market practices. I also agree that FWD has the right to require any of my beneficiaries, claimants, assignees and/or payees to:
   a. provide FWD with their respective personal and financial information;
   b. sign and submit such documents as FWD may reasonably require; and
   c. authorize FWD to disclose such personal and financial information to relevant Filipino and/or foreign government and/or tax authorities.
5. The amounts invested in my policies have been declared to the relevant government and tax authorities (within or outside the Philippines) and none were derived, directly or indirectly, from illegal or unlawful activities and sources or from tax evasion. I authorize FWD to withhold payment of any amounts due to myself, my beneficiaries, claimants, assignees and/or payees if required by any relevant government or tax authorities (within or outside the Philippines).

Place of Signing: _____ Date: m m / d d / y y y y

| Policy Owner's Signature over Printed Name | Insured's Signature *(if different from Policy Owner)* | Irrevocable Beneficiary | Assignee *(if policy is assigned)* | FWP/FSC/Witness |
|---|---|---|---|---|

**Note: (1) If there is more than one irrevocable beneficiary or assignee, indicate signatures at the back of the form. (2) This section must be signed by the Policy Owner, the assignee, and all irrevocable beneficiaries, if any. If any of the irrevocable beneficiary/ies is below 18 years of age or predeceased, additional documents will be required. (3) If this form will be signed outside the Philippines, please have the form authenticated by the nearest Philippine Embassy or Consulate in your locality. (4) The witness should be a disinterested adult person.**

Please Do Not Sign on A Blank Form.