Health Statement Form

Policy Number _____ **Agent Code** _____

Please fill in block letters & 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 said cut-off may be processed the next day.

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

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

Contact Information:

	Country Code	Area Code	Telephone/Mobile Number	
○ Residential Telephone Number	( )	( )		ex: (63)(43)765-4321
○ Business/Office Telephone Number	( )	( )		ex: (63)(2)765-4321
○ Mobile Phone Number	( )	( )		ex: (63)917-7654321

Preferred Mailing Address: ○ Email ○ Business/Office ○ Residence

E-mail Address

If you want to receive notices through e-mail, please be advised that NO hardcopy will be sent to your residence or office.

No. and Street | Barangay/Subdivision

Municipality,Town/City | Province/Country | Zip Code

2.) Service Request/s

- ○ Reinstatement
- ○ Change Plan To: _____
- ○ Remove/Change Rating
- ○ Add Rider: _____
- ○ Adhoc Top Up
- ○ Increase Sum Assured To: _____
- ○ Other Transactions. Please specify: _____

3.) Health Statement

Declaration Please use the space provided to explain a "NO" answer.	OWNER		INSURED		EXPLANATION/DETAILS
	YES	NO	YES	NO	Indicate Diagnosis, Date of Diagnosis, Name and Address of Attending Physician, Medicine, and Result of Test.
1) I am in good health and have never had nor currently have cancer, liver disease (Hepatitis B/C), a lymphatic or blood disorder, blood in the urine or stool or sputum, unexplained loss weight or loss of apetite, recdent change in bowel habits, systemic Lupus Erythematosu, Collagen disease, Myasthenia Gravis, inflammatory bowel disease, HIV infection, AIDS or AIDS related complications , any abnormal/cancer growth tumor or	○	○	○	○	
2) I have not suffered from, been treated for nor have any indication of: chest pain, heart attack, high blood pressure, stroke, diabetes, hepatitis, any disorder of the heart, lung, liver, kidney, spine, joints, digestive system, any mental or nervous disorder, alcoholism, drug abuse, any physical defects or deformities. I have not consulted a specialist and/or not ever been hospitalized and/or undergone any surgical operation and/or ever had a diagnostic test with an abnormal results and/or ever been advised to have any of these in the future.	○	○	○	○	
3) I am not engaged in any hazardous pursuit or occupation e.g. aviation, skin diving, sky diving, motor sports, hand gliding etc.	○	○	○	○	
4) I have no immediate family member who has suffered and died from diabetes, heart problem, stroke, high blood pressure, kidney disease, cancer or other hereditary disease before age 65.	○	○	○	○	
5) I do not have or ever had an application or insurance policy that has been declined,	○	○	○	○	

4.) Affirmation Section

I represent that I am NOT a U.S. citizen, U.S person, U.S. passport holder, or Green Card holder for purpose of U.S. federal income tax and that I am not acting for or on behalf of a U.S. citizen or Green Card holder. If yes, please provide details below: If my tax status changes and I become a U.S. citizen or Green Card holder, I will notify FWD within thirty (30) days. (This clause is not applicable to U.S. citizens or Green Card holders).

◯ U.S. Permanent residence address : _____

◯ U.S. I.D./Passport No./Green Card No. : _____

◯ U.S. Telephone No. : (___) (____) _____

Country Code Area Code Telephone Number

I/We hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of the insured to give FWD Life Insurance Corporation any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This authorization is in connection with the application for reinstatement/policy change/removal or reclassification or rating therefrom. A photographic copy of the authorization shall

I further agree that:

a) If there be any falsity in the answers contained, FWD may, within two years from approval by FWD of the issuance, amendment or reinstatement of policy applied for, regardless of the date of the effectivity requested therefrom by the insured/Policy Owner, declare such issuance, amendment or reinstatement null, void and of no effect;

b) The issuance, amendment or reinstatement applied for shall not be considered as effected by reason of any payment made by the insured/Policy Owner unless and until this application is actually approved by FWD within the life time and good health of the insured (and owner if applicable);

c) FWD shall not be liable for any loss which occurs prior to compliance with FWD's requirements for this application and actual approval thereof;

d) Article 1250 of the Civil Code shall not apply to any payment made or to be made by either party under policy; and

e) No agent of FWD shall have authority to waive any of the foregoing conditions.

I/We hereby agree that should above request be approved by FWD, such request shall, from the date of such approval, amend the relevant Policy provisions in accordance with its terms.

Place Signed _____ Date: m m / d d / y y y y

Policy Owner's Signature over Printed Name	Insured's Signature over Printed Name	Irrevocable Beneficiary	Assignee	Agent/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 beneficiaries is below 18 years of age or has passed away, additional documents will be required. (3) If this form will be signed outside the Philippines, please have the form authenticated by the nearest Philippine Consul in your locality. (4) The witness should be a disinterested adult person.

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.

PLEASE DO NOT SIGN ON A BLANK FORM.

POS FORM HSF061114 V1