PART II APPLICATION FOR INSURANCE TO
ETIQA PHILIPPINES

APPLICANT'S DECLARATIONS OF INSURABILITY TO THE MEDICAL EXAMINER

Subject	First Name	Middle Name	Last Name	SEX

Date of Birth _____
Month Day Year
Place of Birth _____

PLEASE UNDERLINE APPLICABLE ITEMS	YES	NO
1. Have you ever been treated for or ever had any known indication of		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headaches, speech defect, paralysis or stroke: mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough. blood-spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high or low blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice. Intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestine, liver, or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, such as spine, back or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin: lymph glands, cysts, tumor, or cancer?	☐	☐
k. Allergies; anaemia or other disorders of the blood?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐

	YES	NO
2. Are you now under observation or taking treatment?	☐	☐
3. Have you had any change in weight in the past year?	☐	☐
4. Other than Questlons 1 to 3, have you		
a. Had any disease or signs and symptoms of any disease?	☐	☐
b. Had a medical examination, consultation, illness, injury surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility?	☐	☐
d. Had or been advised to have x-ray, electrocardiogram, blood examination or other diagnostic tests?	☐	☐
5. Have you ever applied for or received a pension, payment, or benefit due to injury, sickness, or disability?	☐	☐
6. Have you a parent. brother or sister who died or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease or mental Illness? If so, at what age?	☐	☐
7. FOR FEMALES ONLY		
a. Have you ever had any abnormal menstruation, pregnancy, childbirth or disorder of the female organs or breast?	☐	☐
b. Are you now pregnant? (If yes, indicate how many months and number of previous pregnancies. Check alternative desired) 1. Pregnancy exclusion clause 2. Single extra premium P5/M for one year.	☐	☐

DETAILS OF "YES" ANSWERS TO ANY OF THE QUESTIONS

Question # / Letter	Date/s	DIsease/Signs & Symptoms, Examination/s Done. Purpose and results	Name/s and Addresses of Physicians & Hospitals

The above declaration are true and complete to the best of my knowledge and form Part II of this application for insurance on my life.

Signed at _____ this _____ day of _____, 20_____

_____ _____ _____
Signature of Medical Examiner Signature of Parent, Owned/Legal Guardian Signature of Subject

NOTE 1 If unable to write, affix right thumb mark 2. If subject is under age 18, the parent or legal guardian and owner.
FORM NO. PF-066 must sign in the appropriate space

AUTHORIZATION TO FURNISH MEDICAL INFORMATION
(The form below should be completed for each case)

I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____
_____to Etiqa Philippines any and all Information relative to any hospitalization, consultation, treatment or any other medical advice or examination. A photographic copy of this authorization shall be as valid as the original. The authorization is in connection with my application for insurance only.

_____ _____ _____
Signature of Witness Signature of Owner/Legal Guardian Signature of Subject

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. This becomes Company property and must not be suppressed or destroyed
2. Your report of the person examined should be complete and clear AND IN YOUR OWN HANDWRITING.
3. Any erasures or alterations in any statement made by the subject must be initiated by him, or his guardian, if applicable. Any erasures or alterations in your report should be initialled by you.
4. An Examiner is not permitted to examine relatives, or cases or an agent who is a relative.
5. Please review both sides of the form before submitting to ensure that all applicable questions have been fully and correctly accomplished.
6. If the examination is in connection with an application for reinstatement of a lapsed policy or policy change, the front page of this form is not required to be accomplished.
7. Your report is good for three (3) months. Hence, do not examine the same person more than once within the three-month period
8. A VIOLATION OF ANY OF THE ABOVE, OR ANY FALSIFICATION MADE IN CONNECTION WITH THE MEDICAL EXAMINATION SHALL SUBJECT THE MEDICAL EXAMINER TO A SUSPENSION. OR TERMINATION OF ITS SERVICES WITH **ETIQA PHILIPPINES**

PART III MEDICAL EXAMINER'S REPORT on _____
Print Full Name of Subject

INSTRUCTIONS:
1. In performing the examination, bear in mmd history in Part II.
2. Questions 3 & 4 need not be completed for ages 10 & below.
3. Give details of all "YES' answers.

Submitted in connection with:
☐ New Insurance
☐ Reinstatement of Policy change

1. a. Name and address of Subject's personal physician? _____
(If none, so state) _____
b. Date and reason last consulted? _____
c. Impression or Diagnosis _____
d. Treatment given or medication prescribed? _____

2. a. HEIGHT	WEIGHT	CHEST (full inspiration)	CHEST (forced expiration)	ABDOMEN At Umbilicus
_____ meter	_____ kilos	_____ cm	_____ cm	_____ cm
____Ft. __in	_____ Lbs.	_____ in	_____ in	_____ in

b. Did you weigh & measure subject? ☐ Yes ☐ No

3. BLOOD PRESSURE: (If above 150 systolic or 90 diastolic, report additional readings at 5-minute intervals)

	1st	2nd	3rd
Systolic			
Diastolic			

4. PULSE: (If irregular, rate is over 90 or less than 60 per minute, perform EXERCISE TEST)

	At Rest	After Exercise	3 Minutes Later
Rate per minute			
Irregularities per minute			

*Ten full knee bends from standing position in one minute

5. HEART: Is there any

a) Enlargement? _____ c) Arrythmia?_____

b) Murmur? _____ d) Other Abnormality? _____
(give details and your impression)

6. Is there, on examination, any abnormality of the following: (UNDERLINE APPLICABLE ITEMS AND GIVE DETAILS)	YES	NO
a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing is markedly impaired, indicate degree and correction)	☐	☐
b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
d) Respiratory system?	☐	☐
e) Abdomen (include scars)?	☐	☐
f) Endocrine system (include thyroid & breasts)?	☐	☐
g) Musculoskeletal system (include spine, joints, amputations. deformities)?	☐	☐
7. Is appearance unhealthy or older than age stated?	☐	☐
8. Are you aware of additional information about the health and habits that may affect the risk adversely? (A CONFIDENTIAL REPORT MAY BE SENT TO THE MEDICAL DIRECTOR (or written below))	☐	☐
9. Are you related to the Subject or agent?	☐	☐
10. How long have you known the subject?		
11. URINALYSIS Chemical Urinalysis. (To be performed In all cases) Microscopic (To be performed by the Medical Examiner or any authorized LAB)		

i. Specific: Gravity _____ Pus cells _____
ii. Color: _____ Red Blood Cells _____
iii. Is albumin present? _____ Casts _____
iv. Is sugar present? _____ Others _____
Is urine authentic and voided under circumstances precluding deception?

Microscopic Urinalysis is required if:

1) Age of subject is over 60 yrs. or 2) Amount of Insurance is over P100,000 or 3) Test for Sugar or Albumin is positive, or 4) Blood pressure is over 150 systolic or 90 diastolic, or 5) There is a history or suspicion of urinary tract disorder, hypertension or diabetes.

Full Name of Agent Requesting Examination: _____ Amt. of Insurance _____

I certify that I have carefully examined the person named above and that the examination was made at _____ this* _____ th day of _____ at _____ o'clock AM/PM; that I have asked each question exactly as set forth in Part II and that the Subject's answers thereto are in my handwriting and are exactly as made by the Subject, or his guardian to me and that the Subject and/or his guardian signed the declarations at the bottom of Part II in my presence.

_____ _____ _____
Examiner's Name in Print | Signature of Examiner | Address of Examiner

Medical Fee Stub (Do Not Detach)

Name of Applicant _____ Age _____ Agent Requesting Examination _____

Full Name of Examiner _____ Date of Examination _____ TIN _____

Complete Address of Examiner _____

_____
Signature of Examiner

Fees tor examination are paid only through the Head Office Makati. The Medical Examiner's Report must be completed by the Medical Examiner at the time of examination and submitted to the Company at once so that the fee may be properly credited.