Applicant's Disability Questionnaire

(TO BE ACCOMPLISHED BY THE CLAIMANT OR IF UNABLE TO DO SO, BY LEGAL GUARDIAN OR NEAREST RELATIVE)

Policy No.	1. Full name of insured/payor	2. Occupation (state duties in full)

3. Describe insured's/payor's condition	4. To what extent is insured/payor unable to follow any occupation?
5. Give date of injury or beginning of illness causing present condition(Month/Day/Year)	6. How does insured/payor spend his time?
7. When was insured/payor compelled to give up part of his duties? (Month/Day/Year)	8. When was insured/payor compelled to give up all of his duties? (Month/Day/Year)
9. Has insured/payor done any kind of work since commencement of disability? If so, give particulars.	10. When does insured/payor expect to return to work?
11. If employed, when did insured/payor stop reporting for work? (attach employer's cert. of absences)	12. When is insured/payor expected to report for work?

13. As regards to present affliction, give the name & address of any hospital where confined and of any physician or practitioner who attended to or prescribed for the insured/payor.

DURATION	NAME OF PHYSICIAN/PRACTITIONER/HOSPITAL	ADDRESS

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated, or is now treating me, to impart to ETIQA PHILIPPINES any information it may need.

Dated and signed at ______________________________ on ________________________ 20 __________.

NAME OF WITNESS (PRINT) ______________________________

NAME OF INSURED/ PAYOR/ GUARDIAN/BENEFICIARY ______________________________

SIGNATURE OF WITNESS ______________________________

SIGNATURE OF INSURED/PAYOR/GUARDIAN/BENEFICIARY ______________________________

ADDRESS OF WITNESS ______________________________

ADDRESS OF INSURED/PAYOR/GUARDIAN/BENEFICIARY ______________________________

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