COCOLIFE Building, 6807 Ayala Avenue, Makati City 1226
MCC PO Box 1681 Call Center (632) 8810-7888 Fax No. (632) 8812-9039

HEALTH STATEMENT

POLICY NO. ________________ COMPANY NAME ______________________________

INSURED NAME ______________________________ TELEPHONE NO. ______________________________

NAME OF PAYOR / OWNER OR GUARDIAN ______________________________

DETAILS OF PAYMENT			Medically examined for this application? If "Yes", give Medical Examiner's name.	☐ Yes ☐ No Date Examined
DATE	BANK/APR/OPR DATE & NUMBER	AMOUNT		

Since your last medical examination, non-medical declaration or health statement made in connection with the above policy:	Insured		Payor		Please give full details of any 'YES' answers
	Yes	No	Yes	No	
1. Have you had any illness, injury, hospital confinement, operation, treatment or have you consulted, or been examined by, or received advice from any doctor?					
2. Has there been any change in your health? If "Yes", specify current height and weight.					
3. Have you made any application for insurance / rein-statement which was declined, postponed or modified?					
4. Have you changed your occupation or has there been any change in your avocation (e.g. racing, scuba or sky diving)?					
5. Do you plan to go or work abroad soon? When? Where? Purpose and nature of work? If Seaman, indicate latest port of entry (country/ies).					
6. (For women only) Are you pregnant? If so, how many months?					

I / we hereby declare that each of the above representations is true and correct and that I / we have fully stated all details of each 'Yes' answer.

I / we agree that the issuance, amendment or reinstatement applied for shall not be considered effected by reason of any payment made by me / us unless this application is actually approved by the Company during my / our lifetime and good health and until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied.

I / we agree that any payment made in connection with this application shall be considered as deposit only and shall not bind the Company until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied and until this application is finally approved by the Company during my / our lifetime and good health. If this application is disapproved, I / we also agree to accept the refund of all payments made in connection therewith, without interest, and to surrender the receipts for such payments.

I / we further agree that the issuance, amendment or reinstatement of said Policy, as granted by the Company upon this application, shall be contestable at any time within two years from this date of approval thereof, for fraud or misrepresentation of any material facts therein stated.

Done at ____ on ____

______________________________ SIGNATURE OF WITNESS OVER PRINTED NAME

______________________________ SIGNATURE OF INSURED

______________________________ DETAILS OF ID'S SUBMITTED BY INSURED/PAYOR

______________________________ SIGNATURE OF OWNER / PAYOR