UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION
COCOLIFE Building, 6807 Ayala Avenue, Makati City 1226
Tel. No. 8810-7888 Fax No. 8812-9039 TIN 000-604-739-000 NV Website: www.cocolife.com

PART II - APPLICATION FOR INSURANCE
Declaration of Insurability in Lieu of Medical Exam

ANSWER EACH QUESTION COMPLETELY

1. a. Print Full Name Surname First Name Middle Name Suffix	FAMILY RECORD	If Living		If Deceased	
		Age	State of Health	Age	Cause of Death
b. Date of Birth (mm/dd/yyyy)	Father				
2. Height: _____ft_____in / _____cm Weight: _____lbs / _____kgs	Mother				
3. a. Name address and telephone of your personal physician? (if none, so state)	Wife/Husband				
b. Date and reason last consulted?	Brothers & Sisters No. of living? _____ No. of Dead? _____				
c. What treatment was given or medication prescribed?	Children: No. of living? _____ No. of Dead? _____				

	YES	NO	
4. Have you ever been treated for or ever had any known indication of: a. Disorder of eyes, ears, nose or throat?	☐	☐	**DETAILS OF "YES" answers. IDENTIFY QUESTION NUMBER AND ENCIRCLE APPLIABLE ITEMS. (Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities).**
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental, nervous or other neurological 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 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, other disorder of the stomach, intestines, 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 disorders of the muscles or bones, including the spine, back of joints?	☐	☐	
i. Deformity, lameness or amputation?	☐	☐	
j. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐	
k. Allergies: anemia or other disorder of the blood?	☐	☐	
l. AIDS, AIDS-related complex or conditions or sexually transmitted disease?	☐	☐	
m. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐	
n. Any physical, mental or psychological problems, disorder, illness, injury or impairment not mentioned above?	☐	☐	
5. Have you been or are you now under medication or treatment or taking medicine or intake of cosmetic or hormonal pills or steroid tablets, chemotherapy, radiotherapy or undergone any cosmetic procedure or medical implants?	☐	☐	
6. Have you had any change in weight in the past year?	☐	☐	
7. Other than above, have you within 5 years: a. Had a check-up, consultation, illness, injury or surgery?	☐	☐	9. FOR WOMEN ONLY: a Are you pregnant?_____months_____ b. Date of last delivery?_____ c Any abortions, miscarriage or abnormal labors & pregnancies? If so, give data and causes above _____ d. Have you passed the menopause?_____ e. Have you ever had tumor or disease of the breast, uterus or ovaries? If so give details above _____
b. Been a patient in a hospital, clinic, sanitation or other medical facility or similar institution?	☐	☐	
c. Had electrocardiogram, X-ray other diagnostic test?	☐	☐	
d. Tested positive for antibodies to the AIDS virus?	☐	☐	
e. Been advised to any diagnostic test, hospitalization or surgery which was not completed?	☐	☐	
8. Family history: Tuberculosis, diabetes, cancer, high blood pressure heart or kidney disease, mental illness or suicide?	☐	☐	

I DECLARE for myself and in behalf of any person who shall have or claim any interest in my policy issued hereunder, that each of the above answers is fully complete and true and that to the best of my knowledge I am proper subject for life insurance, and I expressly waive for myself and on behalf of any person who shall have or claim any interest in my policy issued hereunder, my rights under all provisions of law for bidding any physician or other person who attended me or who hereafter attends to or examine me, from disclosing any knowledge of information which he thereby acquired.

I AGREE that should I hereafter apply to the Corporation for additional insurance , the medical report and all the statements herein made by me shall together with such other evidence of insurability that the Corporation may require be the basis for the insurance of said additional insurance.

IMPORTANT NOTICE

The underwriting process (evaluation and classification of risk) is necessary to assure reasonable cost of insurance and provide a mechanism by which policy owners pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements , the result of your physical examination (if required), and any reports we obtain from doctors of medical facilities where you have been attended. An investigative report may also be obtained which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates.

"DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph."

Dated at _____ on _____ .

Witnessed By

_____
Signature and Name in Print of Agent

_____
(Signature of Insured Over Printed Name / Should be the Same as Signature in Application)

_____
(Counter Signature of Parent, if insured is below 18 years old)

Right Thumbmark

AUTHORIZATION TO MY ATTENDING PHYSICIANS

By this form (or a photographic copy of it), I authorized any licensed doctor, medical practitioner, clinic, hospital, or other medical or medically-related facility, insurance company, the Medical Information Database, or other person, organization, or institution, that has any records or knowledge on me or the proposed insured for whom insurance application is made or my health or the proposed insured's health, to give to UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION also known as Cocolife, or its reinsurers, any such information, all to the extent permitted by law.

Dated at _____ on _____

_____
Insured's Signature