



# COCOLIFE

COCOLIFE Building, 6774 Ayala Avenue Makati City 1226  
Tel. No. 812-9015 \* Fax No. 812-9040

## PRELIMINARY INFORMATION REPORT

Use this form for applicants (1) over age 65, or (2) with history of hypertension, coronary disease or diabetes, or (3) who have been highly rated, postponed or declined.

### DO NOT SUBMIT APPLICANT TO A MEDICAL EXAM.

Name of Proposed Insured		Amount of Insurance Desired	Plan
Date of Birth	Place of Birth	Benefits ⌚ WPD      ⌚ ADB      ⌚ ROP      ⌚ Others	
Height	Weight	Total Insurance in Force	
Residence Address		<u>Company</u>	<u>Amount</u> <u>Year Taken</u>
Occupation	Since when so engaged?		
Employer	Has unfavorable action been taken by other companies? <u>Company</u> <u>Amount</u> <u>Year Taken</u>		
Business Address			
Our details of medical history.			
Give name and address of attending physician. (have authorization below signed by proposed insured.) <u>Name and Address</u> <u>Reason for Consultation</u> <u>Date</u>			

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Agent**

### AUTHORIZATION - TO PHYSICIANS, CLINICS, HOSPITALS, LIFE INSURANCE COMPANIES, ETC.

The United Coconut Planters Life Assurance Corporation is considering an application for insurance on my life and I hereby authorize and request you, or any physician, surgeon or other person in your employ or connected / associated with you in any way, to give the Medical Director of said Company, or his authorized representative, any information which he may desire and which you have acquired attending me in a professional capacity. A photostat ( or similar copy ) of this authorization shall be as valid as the original. This authorization is in connection with my application for insurance only.

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Applicant**