PIONEER®
YOUR INSURANCE

INDIVIDUAL APPLICATION AND STATEMENT OF HEALTH FOR GROUP INSURANCE

*For any erasures or ammendments made, kindly countersign.

I. Personal Information

Last Name:	First Name:			Middle Name:
Birthdate (mm/dd/yyyy):	Birthplace:	Age:	Gender:	Civil Status:

Residence Address:	Nationality: ☐ Filipino ☐ Others (Please specify):

Contact Number:	SSS/GSIS Number:	Tax Identification Number (TIN):

Name of Employer/Association:	Name of Creditor (for Group Credit Life):
Office Address:	Term of Loan (for Group Credit Life):
Occupation/Position:	Amount of Loan (if Group Credit Life):

II. Beneficiary Designation

Full Name (Last, First, Middle) of Beneficiary(ies)	Birthdate (mm/dd/yyyy)	Age	Relationship to Insured

III. Statement of Health

For question nos. 5 to 9, if "Yes", kindly provide details required in all columns. You may use a separate sheet, as necessary, with affixed signature and date. Failure to provide details will suspend our evaluation of this application.	Height (ft. & in.):	Weight (lbs):

1. Are you actively at work, performing your daily normal chores of life on a regular, full-time basis?
☐ Yes ☐ No (Please specify):

2. Are you in good health, both physically and mentally?
☐ Yes ☐ No (Please specify):

3. Have you ever had any policy or application for Life, Accident, Disability, Dreaded Diseases, Sickness, or Health Insurance that has been declined, postponed, modified, rated, cancelled or rejected; or was refused for renewal?
☐ Yes (Please provide details in the following table) ☐ No

Date of Application	Insurance Company	Policy Amount	Reason for Refusal/Postponement/Rating

4. Do you have any deformity, impairment of sight, hearing, loss of any body part or other physical defects?
☐ Yes (Please specify):
☐ No

Question	Yes	No
5. Have you ever suffered or do now suffer from:		
a. Circulatory system diseases and heart condition (e.g. Hypertension, Heart disease, Chest pain, Congenital heart defects, etc.)	☐ Yes	☐ No
b. Respiratory system diseases (e.g. Pulmonary Tuberculosis, Bronchial Asthma, Pneumonia, etc.)	☐ Yes	☐ No
c. Genito-urinary system diseases (Polycystic Kidney Disease, Kidney Stones, Urinary Tract Infection, etc.)	☐ Yes	☐ No
e. Nervous system diseases or mental disorders (e.g. Stroke, Paralysis, Multiple Sclerosis, Anxiety, Depression, etc.)	☐ Yes	☐ No
f. Any diseases of the blood (Haemophilia, Leukemia, etc.)	☐ Yes	☐ No
h. Diabetes, thyroid disease, liver disease, cancer/tumor/cyst/lump	☐ Yes	☐ No
i. Any other disease or ailment not mentioned above?	☐ Yes	☐ No
6. Have you ever been confined in any hospital, clinic or similar institution?	☐ Yes	☐ No
7. Have you consulted a physician for any reason?	☐ Yes	☐ No
8. Had any surgical operation or done any diagnostic test such as ECG, X-ray, ultrasound, blood or urine test, CT scan, biopsy or other medical tests carried out for investigative purpose?	☐ Yes	☐ No

9. Has any of your natural parents or siblings suffered from heart disease, stroke, hypertension, kidney disease, diabetes, cancer, paralysis, mental disorder or any hereditary disease?
☐ Yes (Please provide details on the right table)
☐ No

Family Medical History	If living, indicate all past & present medical conditions including age at diagnosis	Present Age	If deceased, indicate cause of death and all past medical conditions prior to death including age at diagnosis	Age at death
Father				
Mother				
Sibling #1 ☐ M ☐ F				
Sibling #2 ☐ M ☐ F				

10. Have you taken alcoholic beverages?
☐ Yes (Please provide details on the right table)
☐ No

Date Started	Date Stopped (if applicable)	Reason for stopping	Type (Beer/Wine/Liquor/ Others)	Quantity (bottle/glass/shot)	Frequency (per day/week/ month/year)

11. Have you smoked cigarettes or used tobacco in any form?
☐ Yes (Please provide details on the right table)
☐ No

Date Started	Date Stopped (if applicable)	Reason for stopping	Type	Quantity (stick/pack)	Frequency (per day/week/ month/year)

For any "Yes" answer to Question Nos. 5-8, please accomplish table below.

Ques-tion No.	Date When Illness Started (mm/dd/yyyy)	Diagnosis / Reason / Any complication	Doctor	Hospital/ Clinic/ Address	Most recent Medical Test/Treatment/ Lab Test	Date of Test/s	Results of Medical Tests	Medication Prescribed and/or maintained	Present Condition (e.g. Normal, uncontrolled) / Other Remarks

I hereby disclose that all statements and answers contained herein are true and complete. In the event that I undergo a medical examination, my statement and representation shall take the place of the above questionnaire for the purpose of this application. I understand that the insurance applied for will not become effective until this application is approved by Pioneer Life Inc. Furthermore, I authorize any medical practitioner, medically related facility, insurance company, or any other person, institution or organization, to provide Pioneer Life Inc. and its reinsurers any information relating to my health and personal identification that they may have. This authorization pertains to my application for insurance and/or policy only. A photocopy of this authorization will be considered as valid and original.

Signature over Printed Name	**Date (mm/dd/yyyy)**

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