



Health Statement Form

1. This form is to be accomplished by the Policy Owner/Assignee in BLOCK LETTERS.
2. Please do not sign on a blank form.
3. Please put a shade in the circle to indicate your choice(s).

☐ Reinstatement ☐ IIE Activation ☐ Increased Sum Insured ☐ Additional Rider
☐ Top-Up Regular ☐ Top-Up Lump Sum ☐ Removal of Temporary Loading

[illegible]

QUESTIONS

QUESTIONS		Insured		Owner		If "yes," please indicate details			
		Yes	No	Yes	No				
a.	Have you ever applied for life, health, accident or disability insurance that has been declined, postponed, rated, modified or renewal refused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
b.	Have you consulted a physician, been referred for test(s) or investigation, had any medical/laboratory test(s) or have been diagnosed or received advice or treatment due to a condition pertaining to heart illness, high blood pressure, lung, kidney, ailment, tumor or cancer, or any other ailment with or without physical impairment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
c.	Have you had any other illness not mentioned above?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
d.	Has there been any change in your occupation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
e.	Have you ever held or intend to be a candidate in a public elective office?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
f.	Have you ever participated in any hazardous sports or activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
g.	Do you smoke cigarettes/cigars? (If yes, indicate no. of sticks/day & no. of years)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	no. of	sticks/day	PI	O
							months/years		
h.	FOR FEMALE ONLY: Are you pregnant or suspecting to be pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	No. of Months _____ Delivery Date _____			

Date Received: _____
Time Received: _____
Receiving
Dept./Office: _____

☐ Without payment

Build Information

		Height	Weight
Please state the height and weight of the Proposed Insured/Owner.	Insured	_____ ft/in	_____ lbs
	Policy owner	_____ ft/in	_____ lbs

Certification of Customary Signature

IMPORTANT: If signature differs between AXA file and documents submitted, please complete this form.

CERTIFICATION OF CUSTOMARY SIGNATURE

This is to certify that I am the same person who signed in the policy contract. I hereby confirm that the declarations and information therein were given by me, and I certify that they are true and complete to the best of my knowledge.

Finally, the signature appearing on all the forms and valid ID/s are my customary signatures and for which reason I have signed both with my customary signatures as follows:

1.

2.

3.

Declarations and Agreement

I agree that the approval of this application is based on the truth of the above statements.

I also agree that if any of the statements above is found to be untrue in any respect and the policy has not been in force during the insured's lifetime for at least two (2) years from the approval date of this application, AXA Philippines shall have the right to declare such reinstatement as null and void.

I also agree that any payment made or to be made by me in connection with the application shall be considered as deposit only and shall not bind AXA Philippines in any manner until the application is finally approved during my or the insured's lifetime and good health. I also understand that if this application is finally disapproved, AXA Philippines will refund any deposit without interest.

IMPORTANT: PLEASE DO NOT SIGN ON A BLANK FORM

Signed at _____ this _____ day of _____.

Signature over printed name of Policy Owner

Signature over printed name of Assignee*, if any

Signature over printed name of Irrevocable Beneficiary*, if any

*If there is more than 1 assignee and or irrevocable beneficiary, please use this portion in indicating their respective names and signatures.

Let's Stay Connected!

We would like to serve you better and keep you abreast with news and information about the Company and your policy. Help us ensure timely delivery of our services by providing us your current contact information.

Here is my updated information:

Mailing Address:

☐ Home ☐ Business

Home No.:

Office No.:

Mobile No.:

Email Address:

YES! I would like to receive news from AXA via:

☐ Mail ☐ Email
☐ Mobile SMS ☐ Personal Call