InLife Benefits
formerly Generali Life Assurance Philippines, Inc.

InLife Benefits Insurance Company, Inc.
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HEALTH STATEMENT FOR LIFE INSURED

APPLICANT'S GENERAL INFORMATION

Company Name			Group Policy No.			
Last Name	First Name		Middle Name			
Date of Birth (MM/DD/YYYY)	Place of Birth	Age	Status	Sex	Height	Weight

	Y	N	DETAILS OF "YES" ANSWERS (PLEASE INDICATE QUESTION NUMBER)
1. Any weight change (lost/gained) of more than 5lbs. during the last 5 months? If so, by how many pounds and why?	☐	☐	
2. Have you ever suffered from or sought medical treatment for:	☐	☐	
a. Epilepsy, fainting attacks or any disorder of the mental or nervous system?	☐	☐	
b. asthma, bronchitis, pleurisy, pneumonia, tuberculosis, or any other lug complaint?	☐	☐	
c. chest pain, high blood pressure, palpitations, shortness of breath, stroke or any heart or circulatory trouble?	☐	☐	
d. indigestion, gastric, or duodenal ulcer, chronic or recurrent diarrhea or any complaint of the stomach or bowels?	☐	☐	
e. diabetes or any disorder of the kidneys, liver, bladder or urinary system?	☐	☐	
f. rheumatic fever, arthritis, gout or any bone or joint disease?	☐	☐	
g. cancer, tumor, enlarged gland or blood disorder?	☐	☐	
h. unexplained recurrent or persistent fever, weight loss or any skin disorder?	☐	☐	
i. any sexually transmitted disease (such as syphilis or gonorrhea) or have you ever sought medical advice, treatment or a blood test in connection with a viral disease (such as hepatitis B or AIDS)?	☐	☐	
j. any other diseases not mentioned above?	☐	☐	
3. Have you ever been diagnosed as suffering from hypertension?	☐	☐	
4. Have you ever been prescribed drugs for this condition?	☐	☐	
5. Have you ever been confined in nursing homes, sanitariums, hospitals for illness, surgical operations, or invasive procedures different from appendectomy, tonsillectomy, adenoidectomy, herniectomy, hemorrhoidectomy, cholecystectomy, child delivery, made within the last five (5) years?	☐	☐	
6. Have you ever been undergone laboratory test or other diagnostic examinations which revealed abnormal results?	☐	☐	
7. Any hospital confinement or surgical procedure being contemplated?	☐	☐	
8. Have you ever received treatment with any blood products or undergone blood transfusion?	☐	☐	
9. Any other disease or complaint not mention above?	☐	☐	
10. Except as prescribed by a physician, have you ever used shabu, cocaine, heroin, marijuana or other narcotics?	☐	☐	
11. Do you smoke or have you ever smoked more than 10 cigarettes per day?	☐	☐	
12. Do you take or have you ever taken more than six units of alcohol per day (1 unit = ½ pint beer/lager, 1 standard glass of wine, 1 pub measure of spirit)?	☐	☐	
13. Have you ever been advised by a physician to stop smoking or drinking alcohol or to drink in moderation?	☐	☐	
14. Are you currently taking medications or are you under medical care of any kind?	☐	☐	
15. For females:			
Are you pregnant?	☐	☐	
Any complications with pregnancy?	☐	☐	
16. Do you have any other application for or reinstatement of life insurance pending? If yes, give details.	☐	☐	

With InLife Benefits Insurance Company, Inc./Inlife Benefits Philippines (INLIFE BENEFITS)

P _____

P _____

With other companies

I, the above-named life insured, declare that to the best of my knowledge and belief the above answers and statements are true, complete and correctly recorded; and agree that, this Health Statement, if approved, with the answers given in any other declaration which may be required by INLIFE BENEFITS and which relates to the insurability of the life insured or to a change in insurance coverage, shall be the basis for delivery, change or reinstatement of insurance coverage.

I agree that:

1. INLIFE BENEFITS shall incur no liability by reason of this Health Statement or by any cash paid or settlement made in connection threwith, until this Health Statement has been approved by INLIFE BENEFITS while I am alive with no change having taken place my insurability subsequent to the date of this Health Statement;

2. All materials facts, being facts which might influence the assessment of this Health Statement, have been truthfully, completely and correctly disclosed in this Health Situation and/or any other declaration which may be required by INLIFE BENEFITS, it being understood that failure to make such disclosure renders the insurance void;

3. If, on the basis of this Health Statement and/or any other declaration which may be required by INLIFE BENEFITS, the insurance coverage is changed so as to result in an increase in the amount of risk, death by suicide, within a period specified in the Suicide Provision of the Policy from the date of this Health Statement, is a risk not assumed under the changed coverage in respect of any increase in the amount of risk;

4. The validity of insurance on any life insured shall not be contested, except for non-payment of premiums, after his insurance has been in force for one(1) year during his lifetime; and;

5. INLIFE BENEFITS reserves the right to deny claims on the basis of gross fraud or valid grounds recognized under the laws and settled jurisprudence in case of death in any year.

SIGNED AT _____ ON _____

_____ _____

SIGNATURE OVER PRINTED NAME OF WITNESS

SIGNATURE OVER PRINTED NAME OF INSURED