

Blood Pressure Supplementary Statement

This statement should be completed by the Proposed Insured/Policyowner

Proposed Insured	Date of Birth
------------------	---------------

Please answer each question **truthfully, accurately** and **completely** and where appropriate, provide particulars.

History

1. When did you notice that you have hypertension? _____
2. What was the blood pressure at that time? _____ mmHg
3. Have investigations been made to determine the cause? YES NO
If YES, what were the results and final diagnosis? (answer below)

Diagnosis

Treatment and Control

Has treatment with antihypertensive or other drugs been given? YES NO

If YES,

- a) When did treatment start? _____
- b) What was the average blood pressure (BP) immediately BEFORE the treatment? _____ mmHg
- c) Please give the sample of the SUBSEQUENT and CURRENT blood pressure levels including pertinent dates.

BLOOD PRESSURE LEVEL (mmHg)	DATE

- d) What drugs are being taken? (Please state dosage)

NAME OF DRUG (Please indicate generic name)	DOSAGE

- e) Do you adhere strictly to the prescribed treatment? YES NO
- f) Is the condition considered to be satisfactorily controlled? YES NO
- g) If treatment has been DISCONTINUED, please give date of cessation? _____

4. Have any COMPLICATIONS of hypertension ever been noted? YES NO
If YES, please give details including the dates and duration of any work interruption?

Please give dates and results of any Chest X-ray, ECG or other tests that have been performed since treatment started.

I hereby declare that the above statements are true and complete and agree that this supplementary statement together with the proposal dated _____ shall form part of the contract between me and Allianz PNB Life Insurance, Inc.
I authorize Allianz PNB Life Insurance, Inc. to process the information I have provided in accordance with the Data Privacy Act.

Signature over printed name of Proposed Insured

Date