NON-MED QUESTIONS

Application No. _____

This form may be used for the following:
1. Applicant Owner with Payor's Benefit Rider
2. Proposed Insured is not acceptable for plan with GAE (Guaranteed Acceptance Endorsement)

Name (last name, first name, middle name) _____

FAMILY HISTORY OF THE APPLICANT OWNER

DECLARATION

Please declare from the immediate family members *(father, mother, siblings)* who developed the following conditions on or before the age of 60.

Condition	Not Applicable	1 member	2 or more members
Cardiovascular Disease/ Coronary Artery Disease / Myocardial Infraction / Hypertension	◯	◯	◯
Cerebrovascular disease / Stroke	◯	◯	◯
Diabetes Mellitus	◯	◯	◯

Condition	Not Applicable	1 member	2 or more members
Alzheimer's / Parkinson's Disease	◯	◯	◯
Polycystic Kidney Disease	◯	◯	◯
Cancer: specify type _____	◯	◯	◯

BUILD

Height _____ ft. _____ in. or _____ cm. Weight _____ lbs. or _____ kg.

Leave questions 1-6 blank if a Medical Examination Report is to be submitted within 7 days from application sign date

1. Have you ever been diagnosed or consulted with a medical doctor, or referred for medical tests or hospitalization for any kind of medical condition **beyond** the conditions listed below? • routine, pre-employment, pre-marriage, annual or physical, immigration and business permit purposes check-up with no **abnormality results** • normal child delivery, previous prenatal check-up with **no high risk pregnancy related condition** • Child Immunization / Child Monthly check up with **no serious findings** • wearing of glasses for short-sightedness, near-sightedness or astigmatism • full recovery from fever / colds / cough/ flu / sinusitis / upper respiratory tract infections **lasting for no more than a month** • successfully recovered from Tonsillectomy, Appendectomy, Cholecystectomy, Minor Bone fracture treatment or surgery **done more than twelve (12) months ago**.	◯ Yes ◯ No	If yes, please indicate the following and submit a copy of the medical report Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):
2. Have you ever been diagnosed or received treatment or medical advice for any **lump, cyst, cancer, high blood, heart** or **lung** disease, **diabetes, kidney** or **liver** disease, **mental** or **neurological** dysfunction, **pending or previous minor or major operation**, or any other ailment with or without physical impairment other than those listed in item number 1?	◯ Yes ◯ No	If yes, please indicate the following and submit the corresponding supplementary statement and a copy of the medical report Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):
3. Do you smoke **more than** 30 sticks per day?	◯ Yes ◯ No	
4. Do you consume alcoholic beverages **more than** 6 bottles beer / 10 shots hard liquor / 4 glasses of wine per day?	◯ Yes ◯ No	
5. Except as prescribed by a physician, have you ever used habit forming drugs (cocaine, heroin, marijuana, LSD or amphetamines)?	◯ Yes ◯ No	If yes, please fill out the Drug Supplementary Statement.
6. For **women** only, are you pregnant? If yes, how many weeks?	◯ Yes ◯ No	

DECLARATIONS ON OCCUPATION/AVOCATION

1. Does the Applicant Owner expect to change:
   a) occupation? ◯ Yes ◯ No If yes, please specify occupation _____
   b) country of residence? ◯ Yes ◯ No If yes, please specify country _____
2. Does the Applicant Owner engage or intend to engage in any private flying, scuba, or skin diving; motorcycle, car, motorboat racing or any other extreme sports/hazardous activities? If yes, please specify activity/activities ◯ Yes ◯ No

_____

Allianz PNB Life Insurance, Inc.
9th Floor, PNB Makati Center, 6754 Ayala Avenue corner Legaspi St., Makati City, Philippines
Tel. No. (632) 8818-LIFE (5433) / TIN 204-145-589-000

Allianz
Allianz PNB Life Insurance, Inc.

I certify that I have fully and accurately recorded to the best of my knowledge and belief all answers given to me.

I declare that all statements I have made are true, completely and correctly recorded to the best of my knowledge and belief. I agree that this shall form part of the corresponding Application for Life Insurance number mentioned on Page 1 of this Non-med form.

Signature over Printed Name of Intermediary

Code

Signature over Printed Name of Applicant Owner

Date (mm/dd/yyyy)

Place