Allianz

Allianz PNB Life Insurance, Inc.

Application for Health Insurance

For Additional Dependents

Attached to Application / Policy No. _____

A ADDITIONAL DEPENDENT INSURED

You may add as Dependents under this application your legal spouse or partner who is living with you, and your unmarried children including any legitimate, illegitimate, or adopted children who are financially dependent on you until their 21st birthday.

1. Name
last name, first name, middle name, suffix

Other Legal Name

2. Place of Birth
City / Municipality, Province, Country

3. Nationality **4. Date of Birth** m m d d y y y y

5. Gender ☐ Male ☐ Female **6. Civil Status** ☐ Single ☐ Widowed ☐ Married ☐ Annulled ☐ Divorced ☐ Separated

7. Country of Residence **8. Duration of Stay** Months

9. TIN / SSS / GSIS No.

10. Present Address

Unit/Building Name | Lot/Block No./ Street No. / Street Name

Barangay / Subdivision | City/Municipality

Province | Country | Zip Code

11. Work Information

Address

Unit/Building Name | Lot/Block No./ Street No. / Street Name

Barangay / Subdivision | City/Municipality

Province | Country | Zip Code

Estimated Annual Income **Occupation**

Employer

Nature of Business

12. Relationship of Owner to Proposed Insured

13. Details of any current domestic or international health insurance

Current insurance provider

Policy Effective Date m m d d y y y y **Policy Number**

14. Commencement of Cover m m d d y y y y

Note: Cover is conditional upon acceptance of your application, which is only confirmed when the Policy Contract is issued to you.

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B PRE-EXISTING CONDITIONS AND HEALTH DECLARATION

PRE-EXISTING CONDITIONS

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during the Insured's lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition which presented signs or symptoms which the Insured was aware of or should reasonably have been aware will be deemed to be a pre-existing condition. Pre-existing conditions disclosed during the application are covered under the policy, unless otherwise advised by us in writing. Conditions arising between the completion of the Application form and the date of entry of an Insured, will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

Please advise us of any material changes to the information provided, between submission of this application and acceptance by us. You are hereby obliged on request to provide any further information that we might require. Full and accurate completion of this Application Form and disclosure of all relevant information are conditions precedent to cover.

HEALTH DECLARATION

Please answer the following questions on the basis of your own and your dependents' complete medical history. All material facts (facts likely to influence our assessment and acceptance of this application) must be disclosed. Failure to do so may invalidate the policy. If you are in any doubt as to whether a fact is material, then it should be disclosed.

Height	⌊⌋⌊⌋⌊⌋ ft	⌊⌋⌊⌋⌊⌋ in	⌊⌋⌊⌋⌊⌋ m	⌊⌋⌊⌋⌊⌋ cm
Weight	⌊⌋⌊⌋⌊⌋ kg	⌊⌋⌊⌋⌊⌋ lbs		
Do you smoke cigarettes or vape?	☐ Yes	☐ No	If yes, no. of sticks/ ml. per day	⌊⌋⌊⌋⌊⌋
Do you consume alcoholic beverages?	☐ Yes	☐ No	If yes, no. of bottles/ glass per day	⌊⌋⌊⌋⌊⌋
Do you wear glasses or contact lenses?	☐ Yes	☐ No	If yes, eye grade	⌊⌋⌊⌋⌊⌋

Instructions: Please check if applicable and provide the full details of the illness or disease in the Additional Information section.

1. Have you ever suffered from or ever had the following illnesses or diseases?

a.	Cancer or any other oncological diseases?	☐
b.	Heart or Blood vessel diseases?	☐
c.	Stroke or any other neurological diseases?	☐
d.	Rheumatoid Arthritis?	☐
e.	Systemic lupus erythematous (lupus) or any other autoimmune diseases?	☐
f.	Psychiatric or psychological illness?	☐
g.	Liver diseases?	☐
h.	Kidney diseases?	☐
i.	Lung or respiratory diseases?	☐

j.	Diabetes Mellitus or any other endocrine diseases?	☐
k.	Gastrointestinal Tract disorders?	☐
l.	Reproductive, gynecological or genital disorders?	☐
m.	Anemia or any other blood diseases?	☐
n.	Urinary or Prostate conditions?	☐
o.	Glaucoma, cataract or any other eye, ear, nose and throat diseases?	☐
p.	Muscular and skeletal disorders?	☐

2. Have you ever:

a.	been tested for HIV, Hepatitis A-B-C or currently awaiting the results of such a test?	☐
b.	been admitted to a hospital or undergone surgery during the last ten (10) years?	☐
c.	been incapacitated or unable to work for a period of more than 2 continuous weeks due to any symptom(s) or medical condition(s)?	☐

3. Are you taking any prescribed medication, any other medical treatment or is under the care of a medical specialist? ☐

4. Have you undergone any medical tests or investigations, or awaiting results, treatment or further tests/ investigations due to any symptom or medical conditions? ☐

5. Do you have any other illnesses, medical condition or symptom(s) not mentioned above? If yes, please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached. ☐

6. Has any of your applications ever been postponed, declined or accepted on special terms by any Insurance Company or Health Maintenance Organization (HMO)? ☐

ADDITIONAL INFORMATION

If you checked any boxes on questions 1 to 6 of the Health Declaration section, please provide details below. We reserve the right to request further medical evidence as part of the full medical underwriting process.

Please advise if a full recovery has been made and if you have any condition or disease related to; or arising from; the original diagnosis. Please enclose up-to-date supporting medical reports/test results if possible.

Question No.	Diagnosis	Date of onset	Frequency and severity of symptoms	Medical test results	Past/Current treatment	Current status

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C GENERAL DECLARATION

1. That these declarations with the answers to the above questions shall be the basis of the Policy and form part of the same;
2. That Article 1250 of the Civil Code of the Philippines (Republic Act 386) relating to extraordinary inflation or deflation shall not apply in determining the extent of liability under the provisions of the Policy;
3. That I hereby waive all provisions of law forbidding any physician, clinic, or other persons from disclosing or giving information or any record pertaining to any consultation, examination, attendance or treatment of the Proposed Insured and/or Applicant Owner if Applicable;
4. That in accordance with the Insurance Commission's Circular Letter No. 2016-54, my information will be uploaded to a Medical Information Database, which includes medical and non-medical information, accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to my information in order to protect my right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph;
5. That I understand that this application form and all test results are subject to underwriting evaluation and that a premium loading may be applied subject to the results of the evaluation. I understand that Allianz PNB Life Insurance, Inc. reserves the right to decline application for coverage based on the results of the evaluation;
6. That I confirm that my country of residence is stated correctly in the Application form and that I have satisfied the minimum six (6) months residency requirement in order to be covered under this policy;
7. That I have read and understood the full definitions, benefits, exclusions and conditions of this policy including the details relating to pre-existing conditions;
8. That If I accept delivery of the Policy and retain the same without objection within 15 days from date of acceptance, such retention shall amount to an approval on my part of the insurance written therein and constitute a ratification by me, of any corrections or additions to this application imposed by Allianz PNB Life Insurance, Inc.;
9. That I am not engaged in any of the unlawful activities listed in the Anti-Money Laundering Act of 2001 as amended and that I declare that the funds where premiums are sourced from, were not generated from any of the unlawful activities listed;
10. That if I decide to transact with Allianz PNB Life Insurance, Inc., through electronic means, I agree to be solely responsible for the safekeeping of my password and/or other electronic identification, and shall hold Allianz PNB Life Insurance, Inc. free and harmless from any and all misuse of such password and/or electronic identification; and
11. That I hereby expressly authorize Allianz PNB Life Insurance, Inc. to obtain, collect, record, organize, store, update, modify, use, share, transfer, disclose and/or destroy ("Process"), whether manually or via electronic channels, any and all information, including personal and sensitive information, about me, the life to be insured, and/or my Policy/ies, to 1) facilitate, monitor and improve the quality of my Policy/ies and such services availed of by me, through programs including but not limited to offer of related products and services, customer satisfaction surveys, and statistical, actuarial and risk analyses, and 2) to comply with legal or regulatory obligations of Allianz PNB Life Insurance, Inc. under applicable local or foreign laws, rules and regulations relating to matters including but not limited to anti-money laundering, and tax monitoring/review/reporting. I also expressly authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose the said information to any of its intermediaries, subsidiaries, affiliates, service providers, partners and government agencies for the said purposes. I likewise promise to inform Allianz PNB Life Insurance, Inc. of any changes relating to my personal information.
12. I also understand that Allianz PNB Life Insurance, Inc. shall communicate with me primarily via electronic channels, i.e. email, SMS, and mobile and web applications. Policy contracts, official receipts and other similar documents will also be sent to me in electronic format if available.

☑ I prefer receiving communications from Allianz PNB Life Insurance, Inc. in paper format. I understand that the notices, disclosures, and similar documents received thru mail or other non-electronic channels might be delayed and will not hold Allianz PNB Life Insurance, Inc. responsible especially if the delay is due to circumstances beyond its control.

☑ I also expressly authorize Allianz PNB Life Insurance, Inc., to share, transfer and/or disclose my information to any of its subsidiaries, affiliates, and partners for offers of related products and services.

D SIGNATURES

If a material fact is not disclosed in this application, any policy issued may not be valid. This includes information that you may have provided to the financial advisor but was not included in the application. If in doubt as to whether a fact is material, you are advised to disclose it. Please check to ensure you are fully satisfied with the information declared in this application.

I certify that I have truly and accurately recorded all information, have seen the original proofs of identification and affirm that the photocopies attached to the application are faithful reproductions of the originals, and have issued and given Applicant Owner a Provisional Receipt for the amount of payment that accompanies the application.

I have personally presented and explained the product and its benefits, have verified the identity of the Proposed Insured and/or Applicant Owner against the identification documents presented, have interviewed them before the application is submitted and have personally witnessed the Proposed Insured and/or Applicant Owner signing the application.

Signature over Printed Name of financial advisor	Code
Date (mm/dd/yyyy)	Place

I declare that all statements I have made are true and complete. I further confirm that these information are recorded accurately.

Signature over Printed Name of Applicant Owner	Signature over Printed Name of Proposed Insured

E AUTHORIZATION TO FURNISH MEDICAL OR OTHER RELATED INFORMATION

Allianz PNB Life Insurance, Inc. is considering an application for insurance on my health and I hereby consent and authorize that:

1. Any physician, clinic, insurance company or other insurance industry association, institution or person that has any record of me and/or the proposed insured named in this application, may release or give to Allianz PNB Life Insurance, Inc. or its authorized representative, any and all information about me and/or the proposed insured named in this application;
2. I, may be subjected to HIV testing for the purpose of underwriting this application or the coverage related to the insurance policy, if issued;
3. A personal investigation on me may be conducted by a duly authorized investigation agency which will provide any applicable information concerning my character, general reputation, personal characteristic, mode of living, health and financial status through personal interviews with friends, neighbours and associates.
4. Any information collected and held by Allianz PNB Life Insurance, Inc. may be released and/or disclosed to its affiliated companies and agents, other insurance companies and their affiliates and any medical information sharing facility of the insurance industry for any legitimate purpose, including but not limited to underwriting and administration of insurance coverage and claims;
5. A photocopy (or similar copy) of this authorization shall be valid as the original. This authorization is in connection with my application for insurance only.

Signature over printed name of Witness	Date (mm/dd/yyyy)
Signature over printed name of Applicant Owner	Signature over printed name of Proposed Insured

TO: ALLIANZ PNB LIFE INSURANCE, INC.

This is to authorize the following to receive my Policy Contract on my behalf:

Complete Name of Authorized Representative:

Last Name, First Name Middle Name	Relationship to Policy Owner
Signature over Printed Name Addressee / Policy Owner	Date

Note: Authorized representative should present a valid ID to the courier before receiving the policy contract.

IF TO BE RECEIVED BY AUTHORIZED REPRESENTATIVE

I acknowledge receipt of Policy No. _____. I declare that I am authorized to receive this policy contract for the addressee/policy owner, and undertake to immediately endorse the said policy contract to the addressee/policy owner as soon as possible.

Signature over Printed Name	Date and Time Received