Allianz PNB LIFE INSURANCE

Application for Health Insurance

Application No. _____

A APPLICANT OWNER INFORMATION

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

Other Legal Name _____

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

3. Nationality _____ **4. Are you a US Person?** ◯ Yes ◯ No

5. Date of Birth ____ ____ ____
m m d d y y y y

For YES, fill up the W-9 Form and the Consent and Waiver Form. If deemed as a non"U.S. Person", fill up the W-8 BEN form to certify that you are a non-U.S. person.

6. Gender ◯ Male ◯ Female **7. Civil Status** ◯ Single ◯ Widowed ◯ Married ◯ Annulled ◯ Divorced ◯ Separated

8. Country of Residence _____ **9. Duration of Stay** ____
Months

10. TIN / SSS / GSIS No. _____

11. Present Address

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

Barangay / Subdivision _____ City/Municipality _____

Province _____ Country _____ Zip Code _____

12. 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 _____

13. Preferred Mailing Address ◯ Present ◯ Work

14. Contact Information (Please provide us accessible contact details for future/any communications)

Primary Contact No. _____
Preferably mobile no.

Secondary Contact No. _____

Email _____

15. Source of Funds ☐ Business ☐ Salary/Commission ☐ Donations/Contributions ☐ Remittances/Allowances/Pension ☐ Investments ☐ Others _____

16. Contingent owner upon death of Applicant Owner

_____
last name, first name, middle name

17. Date of Birth of Contingent Owner ____ ____ ____
m m d d y y y y

18. Relationship of Contingent Owner to Proposed Insured _____

19. Details of any current domestic or international health insurance _____

Current insurance provider _____

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

Allianz PNB LIFE INSURANCE

Application for Health Insurance

B PLAN INFORMATION

1. Base Plan
2. Amount Insured
3. Amount of Payment Deposit
4. Deductible
5. Co Payment
6. 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.

7. Area of Cover:
8. Mode of Payment ☐ Monthly ☐ Quarterly ☐ Semi Annual ☐ Annual
9. Payment Scheme ☐ Cash/Check ☐ Credit Card ☐ Debit Card ☐ Auto Debit

Fill out the applicable form for chosen payment scheme as necessary.

C PROPOSED INSURED Fill out only if different from Applicant Owner

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

Application for Health Insurance

D DEPENDENT INFORMATION Fill out only if with Dependents

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.

DEPENDENT 1

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 _____ **Policy Number** _____
m m d d y y y y

Allianz PNB LIFE INSURANCE

Application for Health Insurance

DEPENDENT 2

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**

If you wish to add more dependents, kindly fill out the Application for Health Insurance for Additional Dependents.

Application for Health Insurance

E 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.

	Applicant Owner / Proposed Insured	Dependent 1	Dependent 2
Height	⌊⌋⌊⌋⌊⌋ ft ⌊⌋⌊⌋⌊⌋ in ⌊⌋⌊⌋⌊⌋ m ⌊⌋⌊⌋⌊⌋ cm	⌊⌋⌊⌋⌊⌋ ft ⌊⌋⌊⌋⌊⌋ in ⌊⌋⌊⌋⌊⌋ m ⌊⌋⌊⌋⌊⌋ cm	⌊⌋⌊⌋⌊⌋ ft ⌊⌋⌊⌋⌊⌋ in ⌊⌋⌊⌋⌊⌋ m ⌊⌋⌊⌋⌊⌋ cm
Weight	⌊⌋⌊⌋⌊⌋ kg / ⌊⌋⌊⌋⌊⌋⌊⌋ lbs	⌊⌋⌊⌋⌊⌋ kg / ⌊⌋⌊⌋⌊⌋⌊⌋ lbs	⌊⌋⌊⌋⌊⌋ kg / ⌊⌋⌊⌋⌊⌋⌊⌋ lbs
Do you smoke cigarettes or vape?	◯ Yes ◯ No If yes, no. of sticks/ ml. per day ⌊⌋⌊⌋⌊⌋⌊⌋	◯ Yes ◯ No If yes, no. of sticks/ ml. per day ⌊⌋⌊⌋⌊⌋⌊⌋	◯ 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 ⌊⌋⌊⌋⌊⌋⌊⌋	◯ Yes ◯ No If yes, no. of bottles/ glass per day ⌊⌋⌊⌋⌊⌋⌊⌋	◯ Yes ◯ No If yes, no. of bottles/ glass per day ⌊⌋⌊⌋⌊⌋⌊⌋
Do you wear glasses or contact lenses?	◯ Yes ◯ No If yes, eye grade ⌊⌋⌊⌋⌊⌋⌊⌋	◯ Yes ◯ No If yes, eye grade ⌊⌋⌊⌋⌊⌋⌊⌋	◯ Yes ◯ No If yes, eye grade ⌊⌋⌊⌋⌊⌋⌊⌋

Allianz PNB LIFE INSURANCE

Application for Health Insurance

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

	Applicant Owner/ Proposed Insured	Dependent 1	Dependent 2
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)?	☐	☐	☐

Application for Health Insurance

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.	Name of the person affected by the condition	Diagnosis	Date of onset	Frequency and severity of symptoms	Medical test results	Past/Current treatment	Current status

Allianz PNB LIFE INSURANCE

Application for Health Insurance

F 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 warrant the eligibility of the beneficiary or beneficiaries named in this application, and further warrant that I shall not, in the future, designate any beneficiary who is ineligible under Articles 2021 and 739 of the Civil Code of the Philippines (Republic Act 386);
4. That should Allianz PNB Life Insurance, Inc. pay the proceeds of the Policy to an ineligible beneficiary, believing in good faith that said beneficiary is eligible, said payment shall free Allianz PNB Life Insurance, Inc. from liability under the Policy, if within sixty (60) days from the presentation by the ineligible beneficiary of the claim and proof of death of the Insured, no adverse claim is filed with Allianz PNB Life Insurance, Inc. by the person legally entitled to the proceeds of the policy;
5. 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;
6. 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;
7. That If I accept delivery of the Policy and retain the same without objection within 15 (for Unit-Linked Plans) 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. in the space "For Home Office Use Only";
8. 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;
9. That during the effectivity of the policy, I agree that in case Allianz PNB Life Insurance, Inc. is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to the fault of the client, Allianz PNB Life Insurance, Inc. may apply the following: a) Measures to restrict the services available or prohibit any further transactions on the policy until full and proper CDD measures have been successfully conducted; b) In case the foregoing is unsuccessful, terminate business relationship. The exercise of Allianz PNB Life Insurance, Inc. of this measure shall only entitle the customer to receive the unused portions of premium or withdrawal value, if any, whichever is applicable;
10. That I am bound by obligations set out in the relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities;
11. 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
12. 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 (Personal Data), about me, the life to be insured, my designated beneficiaries, and if applicable, the beneficial owner/s of my Policy for the following to;
    i. facilitate issuance of my Policy, process claims and other policy benefits , 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, customer satisfaction surveys, and statistical, actuarial and risk analyses;
    ii. 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 shall inform Allianz PNB Life Insurance, Inc. of any changes relating to my Personal Data.

[ ] I further authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose my information to any of its subsidiaries, affiliates, and partners for offer of related products and services.

13. I understand that my policy, including any endorsements, riders and other related documents (Policy), will be sent to me in electronic format. 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. This includes Premium Reminders, Renewal Notices, Reinstatement Notices, and other related documents. If I need a copy of my Policy, notices and other correspondence in paper form, I will contact Allianz PNB Life Insurance, Inc. by sending an e-mail to info@allianzpnblife.ph.

Application for Health Insurance

G 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 and Dependent signing the application.

Signature over Printed Name of financial advisor

Code

Signed in the Philippines on Date (mm/dd/yyyy)

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, if other than Proposed Insured

Signature over Printed Name of Proposed Insured

Signature over Printed Name of Proposed Insured

Signature over Printed Name of Proposed Insured

Application for Health Insurance

H 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 Proposed Insured	Signature over printed name of Proposed Insured
Signature over printed name of Proposed Insured	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

Attestation of the Intermediary

Name of Client (Applicant Owner):
Application No (Application):
Date and Mode of Remote Communication:

During my discussion with the Client, certify that:

1. I have personally presented and explained the product features and its benefits to the Client through remote means of communication.
2. I have explained to the Client in detail the results of the IRPQ as well as the investment risk of his/her chosen fund, the Sales Illustration, and the Financial Needs Analysis (applicable only for UL Products).
3. I have truly and accurately recorded all information provided by the Client in the Application Form under the Client's express consent and instruction.
4. I have performed the Know-Your-Customer and Client Due Diligence procedures as required under the Anti-Money Laundering Act and related laws and have verified the identity of the Proposed Insured and/or the Applicant Owner based on the identification documents presented.

_____ _____
Name of Intermediary Date

Attestation of the Client

Application No (Application):
Name of Product (Plan):
Date and Mode of Remote Communication:

I have discussed with _____ (Intermediary) through remote means of communication and attest and certify the following:
Name of Intermediary

1. That I intend to secure an insurance policy through the Intermediary who explained the features of the product and its benefits, illustrations, of the Plan including applicable riders to me.
2. That the details/declarations stated in the filled out Application Form are correct and based on the information and/or authentic documents provided by me. I personally filled out the application form and/or authorized the Intermediary to fill out the details of the Application Form on my behalf.
3. That I am currently in the Philippines and agree to be bound by the declarations in the said Application Form.
4. That I understand that the integrity and security of this email cannot be guaranteed over the internet, and that I will send email communications only to the correct official email address of my Intermediary.

Applicable only for UL Products:

5. That I fully understand that I will assume all investment risks associated with this Policy.
6. That I confirm that I have signified my consent and acknowledgment as needed in the Sales Illustration, Acknowledgment of Variability, and the Acknowledgment of Guaranteed Acceptance Program and that these shall form part of the insurance contract once issued.

_____ _____
Name of Applicant Owner Date