

NON-MED QUESTIONS

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)

Application No. _____

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cerebrovascular disease / Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes Mellitus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Condition	Not Applicable	1 member	2 or more members
Alzheimer's / Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Polycystic Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer: specify type _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

<p>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?</p> <ul style="list-style-type: none"> • 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. 	<input type="radio"/> Yes <input type="radio"/> No	<p>If yes, please indicate the following and submit a copy of the medical report</p> <p>Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):</p>
<p>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?</p>	<input type="radio"/> Yes <input type="radio"/> No	<p>If yes, please indicate the following and submit the corresponding supplementary statement and a copy of the medical report</p> <p>Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):</p>
<p>3. Do you smoke more than 30 sticks per day?</p>	<input type="radio"/> Yes <input type="radio"/> No	
<p>4. Do you consume alcoholic beverages more than 6 bottles beer / 10 shots hard liquor / 4 glasses of wine per day?</p>	<input type="radio"/> Yes <input type="radio"/> No	
<p>5. Except as prescribed by a physician, have you ever used habit forming drugs (cocaine, heroin, marijuana, LSD or amphetamines)?</p>	<input type="radio"/> Yes <input type="radio"/> No	<p>If yes, please fill out the Drug Supplementary Statement.</p>
<p>6. For women only, are you pregnant? If yes, how many weeks?</p>	<input type="radio"/> Yes <input type="radio"/> 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, Yes No car, motorboat racing or any other extreme sports/hazardous activities? If yes, please specify activity/activities _____

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