FIRST LIFE CENTER 174 Salcedo Street, Legaspi Village, Makati City, 1229 Philippines
Tel. No. (632) 893-3024 Fax No. (632) 816-4707 Web: www.firstlife.com.ph

CI NO. 1008001

GROUP HEALTH DECLARATION FORM

Proposed Insured:

Surname			First Name	Middle Name
Home Address:				
Age	Height	Weight	Sex	Date of Birth
Occupation			Name of Employer	
Business Address				
Amount of Coverage			Term	Premium Paid

Beneficiaries:

Primary:	
Secondary:	

I declare that the following statements are true:

1. That I have not suffered from nor have I been told I have cancer, diabetes, epilepsy, heart trouble, high blood pressure, stroke, chest pain, kidney disease, lung disease, disease of the abdominal organs, disease of the nervous system, AIDS or any other disease not mentioned herein.
2. That I am presently in good health and free from any abnormality or impairment in my condition.
3. That I have not consulted any physician for medical treatment, surgery or advice nor had been confined in a hospital, clinic or medical institution during the past 5 years.
4. That I do not engage or intend to engage in motorcycle, automobile or motorboat racing, sky diving, scuba diving or other hazardous avocations.
5. That I am not currently holding any elective political office in the national or local government or any position in the armed forces or police or self-defense or security unit of any country.
6. That I never had any application for life insurance declined, postponed or accepted with an extra premium.
7. For females only, that I am not pregnant. If pregnant, I am now on my ___ month of pregnancy.

Exceptions to the above statements are as follows: ______________________

I understand that my insurance coverage will be base on the above statements which I represent to be true and correct to the best of my knowledge and that my insurance coverage under this application will not be in-force until I have made my first premium payment during my lifetime and good health. I also understand that non-disclosure of any material information or misleading answers/statements relative to this insurance application may be a ground for denying any claim under the contract of insurance. I authorize any physician, hospital, clinic or other medical facility to furnish First Life Financial Company, Inc. with any information concerning my medical history and physical condition in connection with this application.

______________________ Proposed Insured (Signature over Printed Name)

______________________ Date Signed

NOTE: First Life Financial Company, Inc. reserves the right to accept or decline this application in accordance with its underwriting guidelines.

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STATEMENT OF COVER

GROUP POLICY HOLDER: ______________________

GROUP POLICY NUMBER: ______________________ GROUP POLICY DATE: ______________________

The person named below is insured under the above numbered Policy, subject to all provisions, definitions and limitations thereof, for:

AMOUNT OF LIFE INSURANCE P______________________

Other benefits ______________________ P______________________

______________________ P______________________

______________________ P______________________

NAME OF INSURED: ______________________

EFFECTIVITY DATE: ______________________

BENEFICIARIES: ______________________

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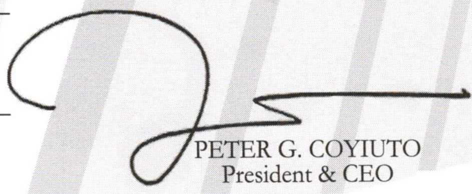

PETER G. COYIUTO
President & CEO

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