1ST LIFE
First Life Financial Company, Inc.
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

Policy Number:_____
Policy Date : _____

NON-MEDICAL QUESTIONNAIRE

Instructions: 1. PLEASE USE BLACK INK IN FILLING OUT THIS APPLICATION; 2. PLEASE WRITE LEGIBLY OR IN PRINT.

Group Policyholder (Employer/Creditor/Assn.)

Client ID No.

Proposed Insured
a. Surname

b. First Name

c. Middle Name

d. Other Names (Maiden Name, Alias, etc.)

e. Date of Birth

Age

f. Place of Birth

Nationality

g. Civil Status ☐ Single ☐ Married ☐ Other
☐ Widowed ☐ Separated Pls. Specifiy _____

Sex ☐ Male ☐ Female

h. Occupation (Give exact duties)

i. Address (check mailing address)
☐ Home

☐ Business

E-mail address

j. Telephone Numbers
Home
Business
Mobile

k. Name and Address of Employer

1. Amount of Insurance applied for

4. Name of Beneficiary/ies				Birthdate			Relationship to Proposed Insured	Designation	
Primary				Mo.	Day	Yr.		Revocable	Irrevocable
Last name	First name	Middle name	Alias or Other Names						
Last name	First name	Middle name	Alias or Other Names						
Last name	First name	Middle name	Alias or Other Names						
Contingent				Mo.	Day	Yr.		Revocable	Irrevocable
Last name	First name	Middle name	Alias or Other Names						
Last name	First name	Middle name	Alias or Other Names						
Trustee				Mo.	Day	Yr.		Revocable	Irrevocable
Last name	First name	Middle name	Alias or Other Names						
Last name	First name	Middle name	Alias or Other Names						

PROPOSED INSURED

	Yes	No
3. Have you		
a. ever made or intend to make any aerial flight other than as a fare-paying passenger on a regular route? If so, complete Aviation Questionnare.		
b. ever driven or intend to drive a motorcyle, or engaged or intend to engage in auto or motor boat racing, sky diving, scuba diving or other hazardous avocations?		
c. ever had any application for insurance or reinstatement of insurance declined, postponed or modified in amount, plan or rate?		
d. any pending application for insurance with us or any other company? If yes, name the company and the amount covered?		
e. during the past 5 years, stayed in a country other than the Philippines for more than 30 days? If yes, name the countries and duration of stay.		
4. Have you smoked cigarettes in the past 12 months ☐ if Yes_____sticks per day		

QUESTIONS TO BE ANSWERED IF APPLICATION IS FOR NON-MEDICAL INSURANCE

5. Have you ever suffered from, been treated for or have any known indications of

If the answer to any question below is "Yes" indicate its letter and give details as to nature of illness, operation or treatment, date and duration, severity and results, name and address of attending physician, clinic or hospital. Please use another page.	Yes	No
a. Stroke, chest pain, high blood pressure, heart disease, or blood disease?		
b. Tuberculosis, asthma or lung trouble?		
c. Diabetes or disease of endocrine glands, disease of kidney? (such as blood, pus, sugar or albumin in the urine, ureters or urinary bladder)		
d. Cancer or tumor, cyst or growth of any kind?		
e. Disease of the mental or nervous system (e.g. epilepsy, fainting attack)?		
f. Disease of stomach, liver (e.g. hepatitis), gall bladder, intestine, or other abdominal organs?		
g. Any other disease not mentioned above?		
h. Surgical operation, medical consultation or treatment?		
i. X-ray, electrocardiogram, urine, blood or other special tests or examinations?		
j. Any physical defect or deformity?		
k. Excessive consumption of alcoholic beverages like beer, wine or spirits? (if so, state daily consumption & whether beer, wine or spirits).		
l. Taken drugs other than those prescribed by a doctor?		
m. Any medical attention other than those mentioned above?		
n. Been tested or told you have AIDS or AIDS related conditions?		
o. A positive blood test for the antibody to the AIDS (HIV, HTLVII) virus?		
p. Unexplained night-sweats and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections or swollen glands?		
q. Gonorrhea, syphilis, strictures or any kind of venereal disease?		
r. Any disease or disorder of the ear, eye, nose or throat?		
s. Arthritis, rheumatic fever, gout or any disorder of the muscles, bones, joints, spine, thyroid or other glands?		

6. a. Height _____ b. Weight _____

c. Have you lost weight during the past 12 months? ☐ Yes No ☐

d. Cause of loss of weight _____

7. FOR WOMEN ONLY

a. Are you pregnant? ☐ Yes_____months ☐ No

b. Any abnormality in menstruation, pregnancy, or of the breast or reproductive organs? ☐ Yes ☐ No

I/WE HEREBY DECLARE AND AGREE THAT:

1. All the foregoing answers/statements and those that I/we may make to the Company's medical examiner (if applicable) in continuation of this application and any amendments thereto are complete, true and correctly recorded and shall form part and be the basis of the insurance contract herein applied for;
2. No agent or medical examiner is authorized to accept risks, pass upon insurability, make/modify contracts or waive any of the Company's rights/requirements.
3. I hereby authorize: a) any insurance organization or the Medical Impairment Bureau to release to the company, and b) the company to release to any insurance organization or the Medical Impairment Bureau any relevant information concerning me whether or not this application is accepted by the company.

Accomplished at_____ this _____ day of _____

_____ Witness (Signature over printed name)

_____ Proposed Insured (Signature over printed name)