Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: (02) 884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife.com.ph
Email: phcustomercare@manulife.com

NON-MED FORM INSURED

DECLARATION OF INSURABILITY OF PROPOSED INSURED IN LIEU OF MEDICAL EXAMINATION

Name (Title) | (Last) | (First) | (Middle) | **Date of Birth** (MM/DD/YYYY)

Present Height: _____ [ ] cm. [ ] ft./in. **Present Weight:** _____ [ ] kg. [ ] lbs.

1. Has your mother, father, brother or sister, had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problem, stroke, hemachromatosis, huntington's disease, polycystic kidney, multiple sclerosis, or any other hereditary disease? [ ] YES *(Please provide details below)* **[ ] NO**

Family Member (Relationship to Proposed Insured)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)

REMINDERS ON DETAILS

Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.

	YES	NO	DETAILS
2. Have you ever had or currently having any disease or disorder of:			
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure, or any other heart disease?	☐	☐	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	☐	☐	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered)?	☐	☐	
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRASMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	☐	☐	
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	☐	☐	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	☐	☐	
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints or spine? Amputation, paralysis, deformity (except sprains and strains which have recovered)?	☐	☐	
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer and any other cancers?	☐	☐	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	☐	☐	
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	☐	☐	
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	☐	☐	
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	☐	☐	
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	☐	☐	
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	☐	☐	
8. How do you describe your drinking habit? ☐ Never drink ☐ Drink up to 14 bottles of beer (or 200ml of wine) per week ☐ Drink more than 14 bottles of beer (or 200ml of wine) per week	☐	☐	
9. Have you been treated for alcohol or drug abuse during the last 5 years?	☐	☐	
10. How do you describe your smoking habit? ☐ Never smoke ☐ Smoke up to 30 cigarettes per day ☐ Smoke more than 30 cigarettes per day	☐	☐	
IF UNDER AGE TWO: Was there any birth difficulty, RH problem, congenital or deformity such as deformed limbs, "blue baby", lack of mental development, or Down's Syndrome?	☐	☐	
If UNDER AGE 17: How much weight was gained in the past year? _____ If none or with loss, give details _____			

NOTE: The company performs random testing covering all insurance applicants. Hence, on a case-to-case basis, for this and other such reasons, the company reserves the right to require medical evidence on the Proposed Insured.

I have read the above questions, statements and answers and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for which this declaration of insurability was required by THE MANUFACTURERS LIFE INSURANCE COMPANY (PHILIPPINES), INC.

Signed at _____ this _____ day of _____, 20_____.

I certify that I have truly read and accurately recorded on the application the information supplied by the Proposed Insured.

_____
Proposed Insured and/or Owner/Payor Signature over printed name

_____
Financial Advisor signature and printed name

Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines
Customer Care: (02) 884-7000
Domestic Toll-Free: 1-800-1-888-6268
Website: www.manulife.com.ph
Email: phcustomercare@manulife.com

NON-MED FORM PAYOR

DECLARATION OF INSURABILITY OF PAYOR IN LIEU OF MEDICAL EXAMINATION

Name (Title) | (Last) | (First) | (Middle) | **Date of Birth** (MM/DD/YYYY)

Present Height: _____ [ ] cm. [ ] ft./in. **Present Weight:** _____ [ ] kg. [ ] lbs.

1. Has your mother, father, brother or sister, had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problem, stroke, hemachromatosis, huntington's disease, polycystic kidney, multiple sclerosis, or any other hereditary disease? **[ ] YES** *(Please provide details below)* **[ ] NO**

Family Member (Relationship to Payor)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)

REMINDERS ON DETAILS

Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.

	YES	NO	DETAILS
2. Have you ever had or currently having any disease or disorder of:			
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure, or any other heart disease?	☐	☐	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	☐	☐	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered)?	☐	☐	
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRASMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	☐	☐	
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	☐	☐	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	☐	☐	
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints or spine? Amputation, paralysis, deformity (except sprains and strains which have recovered)?	☐	☐	
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer and any other cancers?	☐	☐	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	☐	☐	
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	☐	☐	
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	☐	☐	
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	☐	☐	
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	☐	☐	
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	☐	☐	
8. How do you describe your drinking habit? ☐ Never drink ☐ Drink up to 14 bottles of beer (or 200ml of wine) per week ☐ Drink more than 14 bottles of beer (or 200ml of wine) per week	☐	☐	
9. Have you been treated for alcohol or drug abuse during the last 5 years?	☐	☐	
10. How do you describe your smoking habit? ☐ Never smoke ☐ Smoke up to 30 cigarettes per day ☐ Smoke more than 30 cigarettes per day	☐	☐	

NOTE: The company performs random testing covering all insurance applicants. Hence, on a case-to-case basis, for this and other such reasons, the company reserves the right to require medical evidence on the Payor.

I have read the above questions, statements and answers and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for which this declaration of insurability was required by THE MANUFACTURERS LIFE INSURANCE COMPANY (PHILIPPINES), INC.

Signed at _____ **this** _____ **day of** _____, **20**_____.

I certify that I have truly read and accurately recorded on the application the information supplied by the Payor.

_____ _____

Payor and/or Owner signature over printed name **Financial Advisor signature and printed name**