

Complete a separate Part 2 for each person applying for coverage.

Policy No. _____

1. PROPOSED INSURED'S NAME: <i>(Surname, Given Name)</i> _____	DATE OF BIRTH _____	NRIC/SSN/PASSPORT NO. _____
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2. NAME AND ADDRESS OF YOUR PERSONAL PHYSICIAN: _____ _____ _____	3. DATE AND REASON LAST CONSULTED: _____ _____ 4. CURRENT MEDICATION OR TREATMENT: _____ _____
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5. HEIGHT:	WEIGHT:	Has your weight changed more than 15 pounds in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", reason:
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For all "Yes" answers, provide full details on Page 2.

6. WITHIN THE PAST FIVE YEARS HAVE YOU:

- a. Consulted, been examined or been treated by any physician or practitioner? Yes No
- b. Had an X-ray, electrocardiogram or any laboratory test or other diagnostic study? Yes No
- c. Had observation or treatment at a clinic, hospital or other medical facility? Yes No
- d. Had or been advised to have a surgical procedure? Yes No
- e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? . . . Yes No
- f. Had any injury requiring treatment? Yes No
- g. Used nicotine in any form? *(Indicate type, frequency and date last used on Page 2)* Yes No

7. HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:

- a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, or any disease or abnormality of the brain or nervous system? Yes No
- b. High blood pressure, heart attack, heart murmur or palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood? Yes No
- c. Asthma, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs, bronchial tubes, or respiratory system? Yes No
- d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? Yes No
- e. Sugar, protein, or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts or reproductive system? Yes No
- f. Diabetes or any disease or abnormality of the thyroid, adrenal or other glands? Yes No
- g. Arthritis, gout, back trouble, any disease or abnormality of the joints, muscles or bones? Yes No
- h. Any disease or abnormality of the eyes, ears, nose, throat or skin? Yes No
- i. Cancer, tumor, polyp, or cyst? Yes No
- j. Any physical deformity or amputation? Yes No
- k. Anxiety, depression, or any psychiatric or emotional condition or disorder? Yes No
- l. An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, or tested positive on an AIDS/HIV-related test? Yes No

Application Part 2 Non-Medical Health History

8. WITHIN THE PAST TEN YEARS, HAVE YOU USED:

- a. Amphetamines, barbiturates, sedatives or morphine or any other narcotic drug except as prescribed by a physician? Yes No
- b. Cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, PCP, LSD, or any other hallucinogenic drug? Yes No

9. OTHER:

- a. Have your parents, brothers, sisters or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? Yes No
- b. Have you ever been treated or counseled for the use of alcohol or drugs or joined an organization for your alcohol or drug dependence or abuse? Yes No
- c. Has any application for insurance on your life ever been declined, withdrawn, postponed, rated, or modified in any way? Yes No
- d. Are you now pregnant? Yes No

Question Number	Give complete details of all "Yes" answers to questions 6-9, including all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals and attending physicians or counselors. If additional space is required, attach sheet of paper, signed, dated and witnessed.

10. FAMILY HISTORY: Show age and present health, or if deceased, show age at death and cause of death.

	Ages	Present Health	Cause of Death		Ages	Present Health	Cause of Death
Father				Brothers			
Mother				Sisters			

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this Application.

Signed at _____ on _____
City, Country Date (mm/dd/yyyy)

CERTIFICATION: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

X _____
 Signature of Witness/Solicitor

X _____
 Signature of Proposed Insured (of parent or legal guardian if Proposed Insured is a minor)

