Name:_____
Age:_____
Position/ Division/ Office:_____
Amount of Insurance Plan:_____
Date of Birth:_____

Personal Health Declaration

	YES	NO
1. Ever applied for or received disability benefit or pension? If so why?		
2. Ever consulted or been treated by any Physician or other Medical practitioner for any disease pertaining to:		
a. Chest pains, high blood pressure or heart disease?		
b. Diabetes, disease of kidney, ureters and urinary bladder?		
c. Tubercolosis, asthma, or lung disease?		
d. Cancer or tumor?		
e. Nervous or Mental illness?		
f. Disease of the stomach, liver, gallbladder,intestines, or other abdominal organs?		
g. Any other disease not mentioned?		
h. Surgical operation, Medical consultation or treatment?		
i. X-ray, ECG, urine, blood, or other special tests or examinations?		
j. Do you have any defect or deformity		
k. Ever used alcoholic beverages to excess, taken habit forming drugs or sought advice or treatment for alcoholism drug habit or other addiction?		
l. Any medical attention other than those mentioned above?		
3. Lost weight in the last 12 months? If so,how many pounds? Present weight in pounds? Present height in feet and inches?		
4. a. Have you ever had any disorder of menstruation, pregnancy , of the female organ or breast?		
b. To the best of your knowledge and belief, are you now pregnant?		

If answer to any above question 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, clinics or hospitals.

I/We hereby declare that all statements and answers are complete, true and correct. I/We agree that the several answers, statements and agreement contained herein shall be considered part of my application for insurance.

Done at _____this_____day of_____20_____.

_____
Signature of Proposed Insured