PIONEER
YOUR INSURANCE

Individual Application and Statement of Health for Group Insurance

Personal Information

Last Name	First Name	Middle Name		
Birthdate (mm/dd/yyyy)	Birthplace	Age	Sex	Civil Status
Residence Address				Nationality
Contact Number (s)	SSS/GSIS Number	Tax identification Number (TIN)		
Name of Employer/Association/Creditor		Occupation/Position		
Date of Employment/Membership/Loan Approval (mm/dd/yyyy)	Term of Loan (if Group Credit Life)	Amount of Loan (if Group Credit Life)		

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Group Policy No. _____
Certificate No. _____
Effective Date _____

Amount of Insurance:
Basic Life _____
Accident _____
TPD _____
Bereavement _____
Others (pls. specify) _____
NEL issue _____
Excess Over NEL _____

Beneficiary Designation

Full Name (Last, First, Middle) of Beneficiary (ies)	Birthdate (mm/dd/yyyy)	Age	Relationship to Insured

Statement of Health

Reason for Submission of Statement of Health:

☐ Over NEL ☐ Over Age Limit ☐ Late Enrollment ☐ Reinstatement ☐ Others, please specify _____

Height | Weight

General Health Information

1. Are you actively at work, performing your daily normal chores of life on a regular, full-time basis? ☐ Yes ☐ No
2. Are you in good health, both physically and mentally? ☐ Yes ☐ No

Personal Health Information

3. Have you ever had any policy or application for Life, Accident, Disability, Dreaded Diseases, Sickness, or Health Insurance that has been declined, postponed, modified, rated, cancelled or rejected; or was refused for renewal? ☐ Yes ☐ No
4. Do you have any deformity, impairment of sight, hearing, or loss of any body part of other physical defects? ☐ Yes ☐ No
5. Have you during the past 5 years:
   a. Had any injury, ailment, or disease? ☐ Yes ☐ No
   b. Consulted or been treated by any physician or medical practitioner? ☐ Yes ☐ No
   c. Had any surgical operation? ☐ Yes ☐ No
   d. Had any medical examination or check-up? ☐ Yes ☐ No
6. Have you ever been confined in any hospital, clinic or similar institution? ☐ Yes ☐ No

Use this space to provide full details on any "NO" answers to question nos. 1 & 2; and for any "YES" answer to question nos. 3-6. For any "YES" answer to questions 5a-5d, please provide the following: Nature of injury, ailment, or disease; Exact date of occurrence; Symptoms; Treatment/Procedure done and results; and give full name of the attending physician, name of hospital, and complete address. If necessary, use additional sheets, which should be signed and dated.

I hereby disclose that all statements and answers contained herein are true and complete. In the event that I undergo a medical examination, my statement and representation shall take the place of the above questionnaire for the purpose of this application. I understand that the insurance applied for will not become effective until this application is approved by Pioneer Life Inc.

_____ Signature over printed name of applicant

_____ Date(mm/dd/yyyy)

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