



First Guarantee Life Assurance 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

GROUP HEALTH DECLARATION FORM

Proposed Insured:

Surname		First Name		Middle Name
Home Address:				
Age	Height	Weight	Sex	Date of Birth
Occupation			Name of Employer	
Business Address				
Amount of Coverage			Term	Premium Paid

Beneficiaries:

Primary:	
Secondary:	

I declare that the following statements are true:

1. That I have not suffered from nor have I been told I have cancer, diabetes, epilepsy, heart trouble, high blood pressure, stroke, chest pain, kidney disease, lung disease, disease of the abdominal organs, disease of the nervous system, AIDS or any other disease not mentioned herein.
2. That I am presently in good health and free from any abnormality or impairment in my condition.
3. That I have not consulted any physician for medical treatment, surgery or advice nor had been confined in a hospital, clinic or medical institution during the past 5 years.
4. That I do not engage or intend to engage in motorcycle, automobile or motorboat racing, sky diving, scuba diving or other hazardous avocations.
5. That I am not currently holding any elective political office in the national or local government or any position in the armed forces or police or self-defense or security unit of any country.
6. That I never had any application for life insurance declined, postponed or accepted with an extra premium.
7. For females only, that I am not pregnant. If pregnant, I am now on my ___ month of pregnancy.

Exceptions to the above statements are as follows: _____

I understand that my insurance coverage will be based on the above statements which I represent to be true and correct to the best of my knowledge and that my insurance coverage under this application will not be in-force until I have made my first premium payment during my lifetime and good health. I also understand that non-disclosure of any material information or misleading answers/statements relative to this insurance application may be a ground for denying any claim under the contract of insurance. I authorize any physician, hospital, clinic or other medical facility to furnish First Guarantee Life Assurance Company, Inc. with any information concerning my medical history and physical condition in connection with this application.

Proposed Insured (Signature over Printed Name)

Date Signed

NOTE: First Guarantee Life Assurance Company, Inc. reserves the right to accept or decline this application in accordance with its underwriting guidelines.

CI NO. _____



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CERTIFICATE OF INSURANCE

GROUP POLICYHOLDER: _____

GROUP POLICY NUMBER: _____ GROUP POLICY DATE: _____

This certifies that the person named below is insured under the above numbered Policy, subject to all provisions, definitions and limitations thereof, for:

AMOUNT OF LIFE INSURANCE P _____

Other benefits P _____

_____ P _____

_____ P _____

NAME OF INSURED: _____

EFFECTIVITY DATE : _____

BENEFICIARIES: _____

PETER G. COYIUTO
 President & CEO