Beneficial Life Insurance Co., Inc.
(FORMERLY BENEFICIAL-PNB LIFE INSURANCE CO., INC.)
Beneficial Life Building, 166 Salcedo St., Legaspi Village, Makati 1229 P.O. Box 1993
Telephone No.: (632) 818-8671 • Fax Nos.: (632) 818-2291 or 95, (632) 818-2302

FOR BANK USE ONLY
Name of Contact Person - ____________________
Telephone and FAX Number ____________________
Branch/Address ____________________

GROUP MORTGAGE REDEMPTION INSURANCE

APPLICATION FORM

Name of Applicant ____________________ Proposed Coverage ____________________
Address ____________________
Date of Birth ____________________ Place of Birth ____________________
Age ____ Sex ________ Civil Status ________ Height ________ Weight ________ Nationality ________
Tel. No. ____________________ Name/Date of Employment ____________________
Occupation ____________________ Specific Duties ____________________
Amount of Loan Approved ____________________ Term of Loan Approved ____________________
Effective Date ____________________ Termination Date ____________________
Beneficiary/ies ____________________ Relationship ____________________

APPLICANT'S HEALTH STATEMENT

I hereby declare that to the best of my knowledge and belief the following statements/information are true and correct and that I am in good health and I am physically able to perform the usual normal duties of my livelihood.

	YES	NO
A. Have you ever been told you had or been treated for any of the following:		
1. Heart attack, angina pectoris or arteriosclerosis?	[ ]	[ ]
2. Cancer, tumor, diabetes, high blood pressure paralysis or ulcer?	[ ]	[ ]
3. Any disease of the heart, lungs, brain, liver, stomach or kidneys?	[ ]	[ ]
B. Have you ever;		
1. Been declined, postponed or modified in plan or rate for any life or disability insurance?	[ ]	[ ]
2. In the past 2 years lost more than 15 consecutive days from work due to illness, injury, hospital or sanitarium care?	[ ]	[ ]
3. Had any other illness, surgery or hospital care in the past 5 years? (Please give exact date, name, address of all doctors and the reasons for the consultation.)	[ ]	[ ]
C. Have you ever been counseled or medically advised or treated in connection with an HIV infection, AIDS or any Sexually Transmitted Diseased?	[ ]	[ ]
D. Are you pregnant? If so, how many months? (Female applicant only) ________	[ ]	[ ]
E. Have you ever;		
1. Traveled to areas with reporting cases of SARS within the past one month?	[ ]	[ ]
2. Had any close contact of persons diagnosed with SARS or have been placed under quarantine? (Close contact means having cared for, having lived with, or having had direct contact with respiratory secretions and body fluids of a person with SARS)	[ ]	[ ]
3. Been diagnosed or treated for SARS (Severe Acute Respiratory Syndrome)?	[ ]	[ ]

(If any answers are "YES" or any answer is in doubt, please give date and details overleaf.)

I further agree that should my application for insurance under the MRI Policy be approved, such insurance shall be deemed based upon the statements contained in this Health Statement and Applicant's Certificate. I have further executed and on this further condition that if there be any fraud or misinterpretation on said statement material to the risk the insurance shall be considered not to have taken effect.

____________________ ____________________
Date Signature of the Assured

I hereby authorize any person, organization or entity that has any record or knowledge of my health and/or that of ____________________ to give to the BENEFICIAL-PNB LIFE INSURANCE COMPANY, INC. any and all information relative to any hospitalization, consultation, treatment or any other medical advice or examination. This authorization is in connection with my application for group life insurance coverage.

____________________ ____________________
Date Signature of the Assured

INSURER'S COPY