

16. Name of doctor who has given you regular medical attendance for your illness \_\_\_\_\_

17. Name of other doctors not mentioned above who have treated you or been consulted by you. \_\_\_\_\_

18. Have you ever received a pension from any government, or benefit from any life, accident or health company of benefit society or Workmen's Compensation? YES ( ) NO ( ) If yes, state when and from what source. \_\_\_\_\_

I, the undersigned, do solemnly declare the foregoing answer and statements are full, complete and true, and further agree that the furnishing of this form, or any other forms supplemental thereto by the Company, shall not constitute an admission by it that there is any insurance in force in my life or a waiver of any of its rights or defense.

I HEREBY AUTHORIZE any physician or other person, or any hospital, sanitarium or other institution, to furnish the MANILA BANKERS LIFE INSURANCE CORPORATION any information that may be required concerning my illness. I agree that a photocopy of this authorization shall be considered as effective and valid as the original

DATE \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OVER PRINTED NAME

