19. Have you had any operation? YES( ) NO( ) If yes, give details.

NATURE OF OPERATION	DATE

20. What illness(es) have you had prior to your present disability?

NATURE OF ILLNESS(ES)	DATE

21. Name of doctor who has given you regular medical attendance during your disability _____
22. Name other doctors not mentioned above who have treated you or been consulted by you. _____
23. When was the last date you performed your regular occupation or profession? _____
24. What was the nature of your occupation/job immediately prior to becoming totally disabled? Also, state the name of your employer and address.

    Nature of job _____

    Employer's name _____ Address _____

25. If you are not able to perform your regular job functions, could you do lighter work of some sort, such as light clerical or shopwork, light housework, light outdoor work, chores, etc.? YES( ) NO( ) If yes, please state type of work._____

    _____

26. Have you done any work whatever since giving up your usual occupation? YES( ) NO( ) If yes, please give full details.

    _____

27. When do you expect to be able to return to your job? _____
28. Have you any health or accident policies which contain disability benefits or other life insurance policies? YES( ) NO( ) If yes, please give details.

NAME OF COMPANY	YEAR OF ISSUE	AMOUNT OF MONTHLY DISABILITY BENEFIT

29. Have any companies ever declined an application for insurance or disability benefits on your life? YES( ) NO( ) If yes, please name such Companies. _____
30. Have you ever received a pension from any government; or benefit from any life, accident or health company or 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.