

16. (a) Has the patient suffered or is suffering from any other disease or ailment?

If so, please give details:

(b) Date he first suffered the disease or ailment |__|_|_|_|_|_|_|_|_|_|_|

(c) Name of physician consulted _____

17. To your knowledge, is there any family history or any other hereditary disease which would have increase the risk of this disease?

18. Are you completing forms regarding this patient for anyone else, including other insurance companies?

If so, please give details:

19. Please provide us with any other additional information that will enable the company to assess this claim:

I _____ hereby certify that the answers given are full, complete and true. I am a graduate of
(Printed name of Physician)

_____ in _____
(Medical College)

AUTHORIZATION

This authorizes the MANILA BANKERS LIFE INSURANCE CORPORATION or its authorized representative to secure clinical/hospital records relative to the subject's illness, sickness or injury. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Date and signed at _____ on _____

Physician's Signature

PRC No. _____

Date Issued _____

Place Issued _____

Full address of Physician

