HEALTH STATEMENT FORM
(MEDICAL QUESTIONNAIRE)

NAME : ____________________
ADDRESS : ____________________
DATE OF BIRTH : ____________________
PLACE OF BIRTH : ____________________
OCCUPATION : ____________________
LOAN AMOUNT : ____________________

I hereby declare and agree that all the statements and answers contained herein are true, complete and correct to the best of my knowledge and belief and shall form part of my application for MRI insurance. It is understood and agreed that no MRI insurance coverage shall be affected, unless and until this application is approved and the full premium is paid during my continued good health.

1. Do you have or did you have any of the following during the past 5 years? CHECK APPROPRIATE BOX. IF YES, GIVE DETAILS (can use back page): ____________________

	Yes	No
a. Consulted or been treated by any Physician or other Medical Practitioner for any disease pertaining to		
(1) brain or nervous system?	□	□
(2) lungs or respiratory tract?	□	□
(3) heart or blood vessels?	□	□
(4) stomach or any abdominal organ?	□	□
(5) AIDS, AIDS-related complex or AIDS related conditions?	□	□
(6) Any form of cancer	□	□
b. Tested positive for antibodies to the AIDS virus?	□	□
c. Any accident, injury, surgical operation, hospital confinement, medical advise or examination other than those mentioned above?	□	□
d. Dizzy spells; recurrent chest, back, or abdominal pain, persistent cough; blood in the urine; blood spitting?	□	□
e. Any lump or growth in any part of the body or any other physical deformity or abnormality, as impaired hearing or eyesight, lameness or amputation?	□	□
f. X-ray, electrocardiogram (ECG), blood analysis or other diagnostic tests?	□	□

2. For FEMALE ONLY: Are you now pregnant? _____ YES If pregnant, state how many months: _____ months.
_____ NO
3. Present HEIGHT and WEIGHT: ft/in ________________ lbs ________________
Lost weight in the last 12 months? If so, how much and why? ______ YES ______ NO
4. Are you to the best of your knowledge in good health and free from any physical deformity? ___ YES ___ NO
If NO, give details: ____________________

____
Signature Over Printed Name of the
Proposed Insured / Debtor

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

I authorize any physician, hospital, clinic, insurance company, or other organization, or entity, institution, or person that has any records, or knowledge of me, to give HDMF YRT Insurance Pool or its representative any information with reference to health, hospitalization, consultation, advice, examination, treatment, disease, or ailment. A photo static copy of his authorization shall be as effective and as valid as the original. This authorization is in connection with my application for MRI insurance only.

Done at ______________________ this _________ day of ____________ 20 ________

____
Signature Over Printed Name of the
Proposed Insured / Debtor

____
Witness (Print Name & Sign Above)