Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife - Philippines and China Banking Corporation

Medical Evidence Exam Form

See Back Portion

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Please use black ink. Any changes should be initialed by the person answering the questions.

[ ] NB [ ] CS [ ] GROUP

1. Name (Title, Last, First, Middle)	2. Date of Birth

3. Has your mother, father, brother or sister, had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problem, stroke, hemochromatosis, Huntington's disease, polycystic kidney, multiple Sclerosis, or any other hereditary disease? If yes, please provide details below. [ ] Yes [ ] No

Family Member (Relationship to)	Condition/Illness (For cancer/heart disease, specify type)	Age at onset	Age at Death (if applicable)

Name and Address of your Doctor or Clinic (Provide reason and date of last consultation and result)	

SO FAR AS YOU KNOW HAVE YOU EVER HAD ANY DISTURBANCE OF:	✓Check where applicable		Number the answers to correspond to the questions. Give full particulars, conditions, dates, durations and results. Give full names and addresses of doctors, hospitals and clinics
	No	Yes	
4. The HEART, BLOOD VESSEL such as: (a) Have you had high blood pressure or treatment for it?			
(b) Heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever?			
(c) Heart disease, angina or chest discomfort?			
(d) Have you had any electrocardiograms, when, why, result?			
(e) Leg cramps, phlebitis, varicose veins, poor circulation?			
5. The NOSE, THROAT, LUNGS such as: Asthma, tuberculosis, blood spitting, chronic bronchitis, emphysema, tumor?			
6. The ABDOMINAL ORGANS (a) Have you suffered from Hepatitis? Or found to be positive for Hepatitis virus?			
(b) Have you had any ailment on your abdominal organs such as Ulcer, Colitis bleeding, Diverticulitis, Jaundice, Liver Disease, Tumors?			
7. The KIDNEYS, BLADDER, GENITAL ORGANS, such as: Inflammation, stone, tumor, sugar, albumin, blood or pus in the urine?			
8. The NERVOUS SYSTEM, EYES, EARS such as: impairment of sight or hearing, nervous breakdown, seizures, epilepsy, stroke or tumor?			
9. The GLANDULAR SYSTEM, BLOOD such as: Diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, tumor, skin condition or allergy?			
10. The MUSCULO-SKELETAL SYSTEM such as: Any injury or disorder of the muscles, bones, joints or spine?			
Amputation, paralysis, deformity or tumor?			
11. The HEAD AND NECK. Vision, optic fundi, hearing, speech, thyroid, etc.			
12. The SKIN, LYMPH NODES, BREASTS, MUSCLES, BONES, JOINTS OR SPINE			
13. The NERVOUS SYSTEM - Tendon and Pupillary reflexes, Rombergism, weakess or tremors.			
14. Have you had any form of sexually transmitted disease?			
Is there anything about your lifestyle which could expose you to the risks of AIDS?			
15. Are you suffering from AIDS?			
Have you had any test results indicating exposure to the AIDS virus?			
16. Has your weight changed more than 10 lbs. (4.5kg.) in the past year?			
17. So far as you know have you had any illness or injury in the last 5 yrs not mentioned above?			
18. Have you had any X-rays during the last 5 yrs.? Give reasons and results.			
19. Do you now have any disease or symptoms of disease?			
20. Are you currently receiving any treatment or taking any medication?			
21. (a) Do you smoke tobacco or any other substance? If yes, please specify: Type_____Daily consumption_____ No of yrs smoked			
(b) Have you ever in the past smoked tobacco or any other substance? If yes, please specify: Type_____Daily consumption_____ No of yrs smoked_____ Date Stopped_____			
22. Do you drink? If yes, how many standard* drinks do you usually consume per week? *1 standard drink = 360 ml/12 oz Regular beer = 150/5 oz table wine = 45ml/1.5 oz Chinese wine = 30 ml/1 oz Spirit (e.g. Brandy)			
ADDITIONAL QUESTIONS FOR WOMEN: 23. Have you ever suffered from or are you aware of any breast lump or any other disorders of the breast?			
24. Have you ever had an abnormal pap smear, mammogram, ultrasound of the breast, pelvis or any other gynecological investigation or been advised to repeat this test or investigation within the next 12 months?			
25. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?			
26. Any miscarriage or complications of pregnancy?			
27. Are you pregnant? If so, how many months? _____ months.			

I have read the above statements and answers and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the Application for Insurance for which this Medical Evidence was required by MANULIFE CHINABANK LIFE ASSURANCE CORPORATION.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any organization, institution or person, that has any records of me or my health, to give to MANULIFE CHINABANK LIFE ASSURANCE CORPORATION and its reinsurers any such information. This authorization is in connection with my application for insurance only.
A photographic copy of this authorization should be considered valid as the original.

_____ _____ _____
Signature of Proposed Life Insured | Date signed (mm/dd/yyyy) | Place Signed

EXAMINER TO SIGN HERE AND COMPLETE OTHER SIDE:

_____ _____
Printed Name and Signature of Physician | Printed Name of Financial Sales Associate

AUTHORIZATION TO FURNISH MEDICAL OR OTHER RELATED INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or any other organization, institution or person, that has any records of me and_____ to give to MANULIFE CHINABANK LIFE ASSURANCE CORPORATION and its reinsurers any such information. This authorization is in connection with my application for insurance and/or my insurance claim that may arise therefrom. A photographic copy of this authorization shall be considered valid as the original of this authorization shall be considered valid as the original.

_____
Signature of Proposed Life Insured and/or Owner/Payor

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28. Height ___ [ ] cm [ ] ft [ ] inches Weight ___ [ ] kg [ ] lbs	29. BLOOD PRESSURE: (Complete Heart Chart if BP is more than 150/90)					
		Systolic	Diastolic		Systolic	Diastolic
	Sitting			Lying		

Chest inspiration	Expiration	Abdomen	30. Pulse Rate	31. Rhythm

IS THERE EVIDENCE OF PAST OR PRESENT ABNORMALITY OF:	No	Yes	IF YES, GIVE FULL PARTICULARS
32. The CARDIOVASCULAR SYSTEM (a) Heart sounds - Murmurs, before and after exercise (Complete Heart Chart if any murmur)			
(b) Heart size			
(c) Inadequate Circulation anywhere - shortness of breath, edema, stasis dermatitis, peripheral vascular disease			
33. The LUNGS - Chest deformity, emphysema, rales, etc.			
34. The ABDOMEN - Abnormality of any viscus, genitalia or evidence of hernia or operation			
35. URINALYSIS - Urine specimen to be sent if history of kidney disease or sugar or blood pressure more than 150/90. If albumin is present forward two additional specimens taken on different days. (a) Is sugar present?			
(b) Is albumin present?			
(c) Are you sending a specimen?			
36. Do you suspect anything unfavorable such as excessive use of alcohol, cigarettes or drugs?			
37. Are you the attending doctor? If yes, please include a summary of your file information and statement of your additional fee.			
38. From your knowledge of this person, would you consider his/her health to be: [ ] Average [ ] Below Average [ ] Poor			

ADDITIONAL INFORMATION:

I hereby certify that I made an examination on the above subject. I have also verified the identity of the client through his/her:

[ ] Company ID
[ ] TIN
[ ] SSS ID
[ ] Postal ID
[ ] Driver's License
[ ] Passport
[ ] Voter's ID
[ ] Others (Please specify)_____

Time Conducted: _____

_____
Signature of Medical Examiner over printed name

Address: _____
_____

Tin No.: _____
_____