

DECLARATION OF INSURABILITY OF PROPOSED INSURED IN LIEU OF MEDICAL EXAMINATION

Name (Title) (Last)		(First)	(Middle)	Date of Birth (MM/DD/YYYY)
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Present Height: _____ [] cm. [] ft./in. **Present Weight:** _____ [] kg. [] lbs.

1. 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? [] YES (Please provide details below) [] NO

Family Member (Relationship to Proposed Insured)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)	REMINDERS ON DETAILS <small>Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.</small>

2. Have you ever had or currently having any disease or disorder of:	YES	NO		DETAILS
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure, or any other heart disease?	<input type="checkbox"/>	<input type="checkbox"/>		
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	<input type="checkbox"/>	<input type="checkbox"/>		
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered)?	<input type="checkbox"/>	<input type="checkbox"/>		
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRANSMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>		
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	<input type="checkbox"/>	<input type="checkbox"/>		
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	<input type="checkbox"/>	<input type="checkbox"/>		
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints or spine? Amputation, paralysis, deformity (except sprains and strains which have recovered)?	<input type="checkbox"/>	<input type="checkbox"/>		
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer and any other cancers?	<input type="checkbox"/>	<input type="checkbox"/>		
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>		
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	<input type="checkbox"/>	<input type="checkbox"/>		
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>		
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>		
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	<input type="checkbox"/>	<input type="checkbox"/>		
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	<input type="checkbox"/>	<input type="checkbox"/>		
8. How do you describe your drinking habit? <input type="checkbox"/> Never drink <input type="checkbox"/> Drink up to 14 bottles of beer (or 200ml of wine) per week <input type="checkbox"/> Drink more than 14 bottles of beer (or 200ml of wine) per week	<input type="checkbox"/>	<input type="checkbox"/>		
9. Have you been treated for alcohol or drug abuse during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>		
10. How do you describe your smoking habit? <input type="checkbox"/> Never smoke <input type="checkbox"/> Smoke up to 30 cigarettes per day <input type="checkbox"/> Smoke more than 30 cigarettes per day	<input type="checkbox"/>	<input type="checkbox"/>		
IF UNDER AGE TWO: Was there any birth difficulty, RH problem, congenital or deformity such as deformed limbs, "blue baby", lack of mental development, or Down's Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>		
IF UNDER AGE 17: How much weight was gained in the past year? _____ If none or with loss, give details _____				

NOTE: The company performs random testing covering all insurance applicants. Hence, on a case-to-case basis, for this and other such reasons, the company reserves the right to require medical evidence on the Proposed Insured.

I have read the above questions, 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 which this declaration of insurability was required by MANULIFE CHINA BANK LIFE ASSURANCE CORPORATION.

Signed at _____ this _____ day of _____, 20_____.

I certify that I have truly read and accurately recorded on the application the information supplied by the Proposed Insured.

Proposed Insured and/or Owner/Payor Signature over printed name

Financial Sales Associate signature and printed name

DECLARATION OF INSURABILITY OF PAYOR IN LIEU OF MEDICAL EXAMINATION

Name (Title) (Last) _____ (First) _____ (Middle) _____ Date of Birth (MM/DD/YYYY) _____

Present Height: _____ [] cm. [] ft./in. Present Weight: _____ [] kg. [] lbs.

1. 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? [] YES (Please provide details below) [] NO

Family Member (Relationship to Payor)	Condition / Illness (For cancer/heart disease, specify type)	Age at onset	Age at death (if applicable)	REMINDERS ON DETAILS <small>Please label the details with the category and question number (ex. Insured #4A, Payor #5). Give full particulars, conditions, dates, durations and results. Provide full name and address of doctors, hospitals and clinics.</small>

2. Have you ever had or currently having any disease or disorder of:	YES	NO	DETAILS
a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure, or any other heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	<input type="checkbox"/>	<input type="checkbox"/>	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered)?	<input type="checkbox"/>	<input type="checkbox"/>	
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e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	<input type="checkbox"/>	<input type="checkbox"/>	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	<input type="checkbox"/>	<input type="checkbox"/>	
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h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer and any other cancers?	<input type="checkbox"/>	<input type="checkbox"/>	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is there anything about your lifestyle which could expose you to risks of AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has your weight changed more than 10lbs. (4.5kg) in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual check up)?	<input type="checkbox"/>	<input type="checkbox"/>	
8. How do you describe your drinking habit? <input type="checkbox"/> Never drink <input type="checkbox"/> Drink up to 14 bottles of beer (or 200ml of wine) per week <input type="checkbox"/> Drink more than 14 bottles of beer (or 200ml of wine) per week	<input type="checkbox"/>	<input type="checkbox"/>	
9. Have you been treated for alcohol or drug abuse during the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	
10. How do you describe your smoking habit? <input type="checkbox"/> Never smoke <input type="checkbox"/> Smoke up to 30 cigarettes per day <input type="checkbox"/> Smoke more than 30 cigarettes per day	<input type="checkbox"/>	<input type="checkbox"/>	

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I have read the above questions, 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 which this declaration of insurability was required by MANULIFE CHINA BANK LIFE ASSURANCE CORPORATION.

Signed at _____ this _____ day of _____, 20_____.

I certify that I have truly read and accurately recorded on the application the information supplied by the Payor.

Payor and/or Owner signature over printed name _____

Financial Sales Associate signature and printed name _____