# MUTUAL BENEFIT ASSOCIATION, INC
Col Bonny Serrano Road corner E Delos Santos Ave., Quezon City

Proposed Insured : ______________________
Branch of Service : ______________ Rank/Serial No : ______________
Total Amount of Loan : ____________

## Health Declaration for Salary Loan Redemption Insurance (SLRI)

| | YES | NO |
|---|---|---|
| 1. Ever applied for or received disability benefit or pension? If so, why? ______________________ | ☐ | ☐ |
| 2. Ever consulted or been treated by any Physician or other Medical practitioner for any disease pertaining to: | | |
| a. Chest pains, high blood pressure or heart disease? | ☐ | ☐ |
| b. Diabetes, disease of kidney, ureters and urinary bladder? | ☐ | ☐ |
| c. Tuberculosis, asthma, or lung trouble? | ☐ | ☐ |
| d. Cancer or tumor? | ☐ | ☐ |
| e. Nervous or mental illness? | ☐ | ☐ |
| f. Disease of the stomach, liver, gall bladder, intestines or other abdominal organs? | ☐ | ☐ |
| g. Any other disease not mentioned? | ☐ | ☐ |
| h. Surgical operation, medical consultation or treatment? | ☐ | ☐ |
| i. X-ray, ECG, urine, blood, or other special tests or examinations? | ☐ | ☐ |
| j. Do you have any defect or deformity? | ☐ | ☐ |
| k. Ever used alcoholic beverages to excess, taken habit forming drugs or sought advice or treatment for alcoholism, drug habit or other addiction? | ☐ | ☐ |
| l. Any medical attention other than those mentioned above? | ☐ | ☐ |
| 3. Lost weight in the last 12 months? If so, how many pounds? __________ | ☐ | ☐ |

Present weight in pounds: ______________

Present height in feet and inches: ______________

| **FOR FEMALE ONLY** | YES | NO |
|---|---|---|
| 4. a. Have you ever had any disorder of menstruation, pregnancy, female organ or breast? | ☐ | ☐ |
| b. To the best of your knowledge and belief, are you now pregnant? | ☐ | ☐ |

**Note:** If answer to any question above is "YES", indicate and give details on the nature of illness, operation or treatment, date and duration, severity and results, name and address of attending physician, clinics or hospitals. Use the back portion of this questionnaire.

I hereby declare that all statements and answers are complete, true and correct. I agree that the several answers, statements and agreement contained herein shall be considered part of my application for insurance.

Done at ____________________ this __________ day of ______________ 20_____.

______________________
Signature of Proposed Insured

## DETAILS AS TO THE NATURE OF ILLNESS

Nature of Illness : ______________________________

Operation or Treatment : ______________________________

Date and Duration : ______________________________

Severity : ______________________________

Medical Examination Results : ______________________________

Clinics or Hospitals : ______________________________

Name and Address of Attending Physician : ______________________________

______________________________

Other information covering illness: ______________________________

______________________________

______________________________

Printed Name &
Signature of the Proposed Insured/ Borrower