

**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?	<input type="checkbox"/>	<input type="checkbox"/>
(2) lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>
(3) heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>
(4) stomach or any abdominal organ?	<input type="checkbox"/>	<input type="checkbox"/>
(5) AIDS, AIDS-related complex or AIDS related conditions?	<input type="checkbox"/>	<input type="checkbox"/>
(6) Any form of cancer	<input type="checkbox"/>	<input type="checkbox"/>
b. Tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
c. Any accident, injury, surgical operation, hospital confinement, medical advise or examination other than those mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
d. Dizzy spells; recurrent chest, back, or abdominal pain, persistent cough; blood in the urine; blood spitting?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
f. X-ray, electrocardiogram (ECG), blood analysis or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>
2. For FEMALE ONLY: Are you now pregnant? <input type="checkbox"/> YES If pregnant, state how many months: _____ months. <input type="checkbox"/> NO		
3. Present HEIGHT and WEIGHT: ft/in _____ lbs _____ Lost weight in the last 12 months? If so, how much and why? <input type="checkbox"/> YES <input type="checkbox"/> NO		
4. Are you to the best of your knowledge in good health and free from any physical deformity? <input type="checkbox"/> YES <input type="checkbox"/> 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)