APPLICATION FORM

OONA GLOBAL SHIELD

A BASIC DETAILS

In the next 12 months, do you or any immediate family member plan to live or work outside the Philippines? Yes: ☐ No:

POLICYHOLDER

Full name

ID type

ID number

Date of birth

Sex

Nationality

Mobile number

Email

Occupation

Permanent address (in the Philippines)

Province

City

Address line 1

Address line 2

B HEALTH DETAILS

1 Are all individuals proposed for insurance under this application currently covered by any medical insurance policy? Yes: ☐ No:

2 Basic biometrics Height: Weight:

3 Do you currently smoke or have you used any tobacco, nicotine products (including cigarettes, vapes, patches, or gum) in the past 12 months? Yes: ☐ No: ☐

How long have you been smoking? __ year(s) __ month(s)

If you are still smoking, how many cigarette sticks do you smoke per day? _____ stick(s) per day

If you no longer smoke, how many years has it been since you last smoked? _____ year(s)

4 Are you currently covered under PhilHealth? Yes: ☐ No: ☐

5 Has any of your life insurance applications ever been declined, postponed, or accepted with special terms (e.g., extra premiums or coverage restrictions) Yes: ☐ No: ☐

Type of Insurance _____

Outcome of your application Declined ☐ Application with Special Terms ☐ Postponed ☐

6 Do you consume wine, beer, or other alcoholic beverages? Yes: ☐ No: ☐

Type of alcoholic beverage _____
Frequency _____ Weekly Quantity _____ Unit Glass ☐ ML ☐

7 Have you ever used addictive drugs or narcotics, engaged in substance abuse (including glue sniffing), or been treated for drug addiction or alcoholism? Yes: ☐ No: ☐

8 Do you participate in any sports or occupations considered dangerous or hazardous, such as motor racing, scuba diving, skydiving, or military or private flying (other than as a fare-paying passenger)? Yes: ☐ No: ☐

Please provide details _____

9 Have any of your natural parents or siblings been diagnosed with cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorders, tuberculosis, or any other hereditary conditions? Yes: ☐ No: ☐

Relationship to the insured _____

Medical Condition (Diagnosis) _____

Age at the time of diagnosis _____ years(s) Age of death (if deceased) _____

10 In the past 3 months, have you experienced any of the following symptoms continuously for more than one week: fatigue, unexplained weight loss, enlarged lymph nodes, or unusual skin lesions? Yes: ☐ No: ☐

Medical Condition _____

Treatment _____

Present Condition _____

Date of such treatment _____

Date of last follow up medical condition _____

Name of Doctor _____

Name of Hospital _____

11 In the past 5 years, have you undergone or been advised by a doctor to undergo any medical investigations, including but not limited to X-rays, ultrasounds, heart scans, CT scans, MRIs, biopsies, endoscopies, gastroscopies, colonoscopies, or surgical procedures? Yes: ☐ No: ☐

Medical Condition _____

Treatment _____

Present Condition _____

Date of such treatment _____

Date of last follow up medical condition _____

Name of Doctor _____

Name of Hospital _____

12 Are you currently taking any medication for more than one month, or undergoing any ongoing medical treatment? Yes: ☐ No: ☐

Medical Condition_____

Treatment _____

Present Condition _____

Date of such treatment _____

Date of last follow up medical condition _____

Name of Doctor _____

Name of Hospital _____

13 Have you ever experienced symptoms of, been diagnosed with, or received treatment for any of the following conditions?

a. Speech defect, paralysis, hearing loss, physical or birth defect, infirmity, congenital/hereditary illness or chronic condition? Yes: ☐ No: ☐

b. Ear discharge, nose bleeds, double vision, impaired sight, respiratory or allergic condition or disorder of the eye, ear, nose or throat? Yes: ☐ No: ☐

c. Epilepsy, fits, paralysis, dementia, Parkinson's disease, multiple sclerosis, stroke, seizure or fit, swelling or dislocation of a limb, Yes: ☐ No: ☐

prolonged headache, blackout, fainting, mood change, sleep disorder/insomnia,or any other nervous or mental disorder(s) or disease of the brain?

d. Blood pressure problem, chest pain, cholesterol problem, dizziness, anemia, heart murmur, breathlessness, abnormal heart rate, heart attack, coronary artery disease, rheumatic fever, varicose veins, and/or any disease/disorder of the heart or blood vessels? Yes: ☐ No: ☐

e. Jaundice, hepatitis of any form, gall/kidney stone, venereal disease, or disorder of the bladder/urination, prostate, kidney, genitourinary tract or pancreas? Yes: ☐ No: ☐

f. Indigestion, irritable bowel syndrome, gastritis, ulcer, blood in stools, fistula, hernia, hemorrhoid,colitis or stomach, liver or bowel disorders? Yes: ☐ No: ☐

g. Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, bone fracture, joint pain or joint injury (e.g., knee, elbow, wrist, shoulder), hallux valgus (hammer toes), muscle disorder, arthritis, joint or bone disease? Yes: ☐ No: ☐

h. HIV, AIDS/AIDS Related Complex or any indication of blood or immune system connective tissue disorder? Yes: ☐ No: ☐

i. Any form of cancer, mass, lump, cyst, tumor or growth of any kind? Yes: ☐ No: ☐

j. Psoriasis, eczema, dermatitis, acne or any other skin condition? Yes: ☐ No: ☐

k. Diabetes Yes: ☐ No: ☐

l. Thyroid (ex: goiter)/parathyroid disorder Yes: ☐ No: ☐

m. Obesity Yes: ☐ No: ☐

n. Endocrine tumors Yes: ☐ No: ☐

o. Other hormone, endocrine or glandular disorder or condition (Please specify.) Yes: ☐ No: ☐

Medical Condition_____

Treatment_____

Present Condition _____

Date of such treatment _____

Date of last follow up medical condition _____

Name of Doctor _____

Name of Hospital _____

NOTES

I _____ confirm that:

- I have understood and agree to the above details and document(s).
- The signature below will be applied to the above Application Form and Endorsement(s), if any.
- All of the information provided is true and complete. I understand that any undisclosed information, misrepresentation, or falsification may result in the insurer's right to decline my or any of the insured's claim or cancel the policy retroactively.
- I have read and accept the **Terms & Conditions** and **Privacy Policy**.

CONFORME:

_____

OONA INSURANCE CORPORATION

_____

AUTHORIZED SIGNATURE