Allianz PNB LIFE INSURANCE

Health Insurance Service Request

Policy No. _____

GENERAL INFORMATION

Policy Owner's Name (Last Name, First Name, Middle Name)

Mobile No. (Required)

Email Address (Required)

Mailing Address:

Kindly accomplish the relevant sections if you wish to make any of the following changes to your health insurance policy:

- ☐ Add/Remove Dependents (Section A)
- ☐ Change Plan (Section B)
- ☐ Change Owner(Section C)
- ☐ Reinstate Plan (Section D)
- ☐ Change of Name (Section E)
- ☐ Change of Nationality (Section F)
- ☐ Change of Mode of Payment (Section G)
- ☐ Change of Payment Scheme (Section H)

A. ADD / REMOVE DEPENDENTS

I wish to add the following family members as dependents under my plan:

Full Name (Last Name, First Name, Middle Name)	Date of Birth (MM/DD/YYYY)

IMPORTANT: For additional dependents, kindly fill up and attach the applicable Health Insurance Application Form to provide details necessary for underwriting.

I wish to remove the following family members as dependents under my plan:

Full Name (Last Name, First Name, Middle Name)	Date of Birth (MM/DD/YYYY)

B. CHANGE PLAN – TO TAKE EFFECT ONLY UPON POLICY RENEWAL

I want to change the following:

	From	To
☐ Level of Cover		
☐ Area of Cover		
☐ Annual Deductible		
☐ Others (please indicate)		

IMPORTANT: If level or area of cover is increased, or amount of annual deductible is decreased, kindly fill out the Health Statement in the next page.

C. CHANGE OWNER – TO TAKE EFFECT ONLY UPON POLICY RENEWAL

I wish to change the Owner of this Health Insurance Policy.

Proposed Owner's Name (Last Name, First Name, Middle Name)

Date of Birth (MM/DD/YYYY)

Relationship to Insured:

Mobile No. (Required)

Email Address (Required)

Mailing Address:

IMPORTANT: The new proposed owner must be covered in an existing policy of the same health insurance plan and should either be spouse or parent of the Insured.

D. REINSTATE PLAN *(Please answer the Health Statement below if you wish to reinstate your plan.)*

HEALTH STATEMENT

Please answer the following health questions if you wish to upgrade or reinstate you International Health Insurance Plan. Use additional sheets to indicate answer for additional dependents.

	Owner Insured	Dependent 1	Dependent 2
Height	ft. in.	ft. in.	ft. in.
Weight	lbs.	lbs.	lbs.

Since your last medical examination, medical declaration, health statement or other information made in connection with the above- number policy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
1. Have you had any illness, injury, operation, treatment or medicine taken or have your consulted or been examined, advised by any doctor?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Has there been any change in your height and weight?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Has there been any change in your health?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you made any application for insurance/reinstatement with another insurance company which was declined, postponed or modified?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you changed your occupation?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you changed your place of residence or do you plan to work abroad soon? *Please indicate when, where, duration of stay and in what capacity in the space provided below.*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Additional Information on YES answers.

If you answered 'Yes' to any part of questions 1 to 6 of the Health Statement please provide details in the table below.

Question Number	Applicable to	Details
	☐ Owner Insured ☐ Dependent 1 ☐ Dependent 2	
	☐ Owner Insured ☐ Dependent 1 ☐ Dependent 2	
	☐ Owner Insured ☐ Dependent 1 ☐ Dependent 2	
	☐ Owner Insured ☐ Dependent 1 ☐ Dependent 2	

E. CHANGE OF NAME

Change of name: ☐ **Owner** ☐ **Insured**

From: _____ To: _____

Reason: ☐ Marriage ☐ Separation ☐ Court Order ☐ Others (pls. Specify) _____

F. CHANGE OF NATIONALITY

From: _____ To: _____

G. CHANGE OF MODE OF PAYMENT

☐ **Annual** ☐ **Semi-annual** ☐ **Quarterly** ☐ **Monthly**

H. CHANGE OF PAYMENT SCHEME **Accomplish required forms*

☐ **Cash/Check** ☐ **Auto-Debit*** ☐ **Credit Card*** ☐ **Others**

DECLARATION

I/We hereby declare that the information provided is true, correct, and complete and that I/we have withheld no material information. I also understand that any concealment or misrepresentation may be a ground for refusal of my request/s.

AUTHORIZATION

I/We hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, government institution or private company or entity that has any record or knowledge, to give to Allianz PNB Life Insurance, Inc. or its representative, any information whatsoever with reference to health, hospitalization, consultation, advice, examination, treatment or ailment, birth, death, marriage, employment and education of the Insured. A photocopy of this authorization shall be as effective and valid as the original.

Signed at _____ this _____ day of _____.

Signature over Printed Name of Witness

Signature over Printed Name of Owner, if other than Proposed Insured

Date Signed (mm/dd/yyyy)

Signature over Printed Name of Insured

Signature over Printed Name of Insured

CONTACT US: **24/7 HOTLINE: (+632) 818 HELP (4357)**
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