PARAMOUNT
LIFE & GENERAL
INSURANCE

14th Floor, Sage House, 110 V.A. Rufino St.,
Legaspi Village, Makati City, 1229 Philippines
Tel. No.: +(632) 8772 9200
Fax No.: +(632) 8772 9297
www.paramount.com.ph

APPLICANT'S DISABILITY QUESTIONNAIRE

(To be accomplished by the claimant or if unable to do so, by legal guardian or nearest relative)

1. Policy No.	2. Full Name of Insured/Payor	3. Occupation (state duties in full)

4. Describe insured's/ payor's condition	5. To what extent is insured/payor unable to pursue any occupation?
6. Give date of injury or beginning or illness causing present condition (MONTH/DAY/YEAR).	7. How does insured/payor spend his time?
8. When was insured/payor compelled to give up part of his duties? (MONTH/DAY/YEAR)	9. When was insured/payor compelled to give up all of his duties? (MONTH/DAY/YEAR)
10. Has insured/payor done any kind of work since commencement of disability? If so, give particulars.	11. When does insured/payor expect to return to work?
12. If employed, when did insured/payor stop reporting for work? (Please attach employer's certificate of absences)	13. When is insured/payor expected to report for work?

14. As regards present affliction, give the name and address of any hospital where confined and of any physician or practitioner who attended to or prescribed for the insured/payor.

DURATION	NAME OF PHYSICIAN/PRACTITIONER/HOSPITAL	ADDRESS

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated, or is now treating me, to impart to PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION, any information it may need.

Date and signed at ______________________________ on __________ year __________________ , 20 ______

________________________ Name of Witness (Print)

________________________ Signature of Insured/Payor/Guardian/Beneficiary

________________________ Signature of Witness

________________________ Address of Insured/Payor/Guardian/Beneficiary

________________________ Address of Witness