RESET / CLEAR FORM

PARAMOUNT
LIFE & GENERAL
INSURANCE

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ATTENDING PHYSICIAN'S STATEMENT

(Claim under the Disability Waiver Certificate)

NOTE: Please use reverse side for answers requiring additional information not called for in this questionnaire. Identify your answers with corresponding item numbers.

CLAIMANT		DISABILITY	
1. Name		**16. How would you classify the disability?** ☐ Total Permanent ☐ Partial Permanent ☐ Total Temporary ☐ Partial Temporary	
2. Address		**If partial, what in your opinion is the degree of Incapacity?**	
3. Occupation	**4. Apparent Age**	**17. If totally disabled, since when?**	**18. Is he totally disabled?**
5. Height	**6. Weight**		

MEDICAL HISTORY		MEDICAL HISTORY
7. Are you his regular physician?	**8. How long have you known him?**	**19. What is your diagnosis?** **Interpretation, if any of Laboratory reports:** **X-ray:** **Electrocardiogram:**
9. When did you first visit him for his present illness?		
10. Have you previously attended him? If so, **WHEN?** / **FOR WHAT?**		
11. Has there been treatment by any other physician? If so, give their names and dates.		
12. Has he received treatment in any hospital, sanitarium or other institution? If so, state where and when.		**20. Was there any predisposing or contributing cause, remote or recent, for the present disability in the family history, occupation or previous illness of the Insured? If so, describe fully.**
13. What and when were the earliest indications of illness noted by the insured? Give basis.		
14. When, in your opinion did the illness which directly or indirectly caused the disability commence?		**21. Is any surgical operation contemplated or has one been performed? If so,** What ? _____ When? _____ Where? _____ By whom? _____
15. Was he in good health up to the time of this present illness? If not, give details.		**PROGNOSIS** **22. What is the prognosis?**

FRAUD WARNING

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

DATA PRIVACY CONSENT STATEMENTS

I hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, customer/client profiling, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), its subsidiaries, affiliates, directors, officers, employees, and agents (a) to verify and/or confirm any or all the information provided or representation made, (b) to provide, facilitate, monitor, improve the quality of, or otherwise service my account and such products, services, and facilities and/or channels availed by me or may be offered by PLGIC, and (c) to comply with legal, regulatory or other obligations of PLGIC under applicable local or foreign laws, rules and regulations.

I likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, and customer/client profiling, by authorized third parties for the foregoing purposes.

Such processing may be conducted for the duration of my availment of PLGIC's products, services, facilities and/or channels. I further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties, of my personal data which may be inaccurate or incorrect.

I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided. I understand and agree that the consent hereby given may be revoked or withdrawn though formal written notice to PLGIC.

Finally, I authorize PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties to obtain such other information they may deem necessary to verify or confirm the personal data declared or the documents furnished in relation to this application, and that I agree that such documents may remain in the possession of PLGIC whether or not this application is granted, for the purposes above mentioned.

I, _____ **hereby certify that the answers given above are full, complete and true, I am**
(Printed name of Physician)

a graduate of _____ **in the year** _____
(Medical College)

_____ _____
Signature of Insured — Phyisician's Signature
(Must be signed in the presence of the attending phyisician)

_____ _____
Date — Address in full