AUTHORIZATION TO MY ATTENDING PHYSICIANS

This portion (or photostatic copy of it) authorizes you to give the Knights of Columbus Fraternal Association of the Philippines, Inc., any and all information you may have regarding my condition when under observation or treatment by you, including the history obtained, finding, and diagnosis.

_____ Applicant's Signature (This must be signed by father or mother of applicant if he/she is below 18 years old)

_____ Date

KNIGHTS OF COLUMBUS
FRATERNAL ASSOCIATION OF THE PHILIPPINES, INC. (KCFAPI)

Part 2
OF APPLICATION

Applicant's Declaration of Insurability

Every question must be asked the applicant by the Medical Examiner and the applicant's answer recorded in the Examiner's own handwriting and in Black ink.

1 a. Print Full Name (First) (Middle) (Last)

b. Date of Birth

c. Place of Birth

d. Civil Status ◯ Single ◯ Married ◯ Separated ◯ Widowed ◯ Divorced

e. Sex ◯ Male ◯ Female

e. Address

FAMILY RECORD	If Living		If Deceased	
	Age	State of Health	Age	Cause of Death
Father				
Mother				
Wife/Husband				
Brothers/Sisters No. of Living No. of Dead				
Children No. of Living No. of Dead				

2 a. Occupation

b. Have you for physical reason ever been refused or discharged from employment, military or naval service? If Yes, please state details

b. Have you applied for or received disability benefits or pension from any source? If Yes, details please.

3 a. Has any life insurance company ever refused your application for insurance or for reinstatement of a lapsed policy or offered you a policy different from that applied for? When? What Company?

b. Have you an application pending in another company? What Company?

4 When did you last consult a physician? _____ 20

For what? _____

Results? _____

His Name _____

Address? _____

5 Name and address of Family Physician? _____

6 Have you lost weight during the past 12 months? How many pounds? Why?

7 Are you now or have you been associated with a tubercular?

Date with whom?

8 a What alcoholic beverages do you use? How often?

b Have you used them to excess or intoxication? How often?

c Do you use or have you ever used any habit forming drug? Kind?

d Have you ever taken any treatment for the cure of any drug or alcoholic habit?

Date? Kind? Under whose advice?

9 Have you ever been in a hospital, clinic, or institution for observation, treatment or operation?

Date? _____

For what? _____

name of Institution? _____

Name of Physician? _____

Address? _____

10 a Have you any physical defects? What is it?

b Are you now in good health? If not, why?

11 HAVE YOU EVER HAD: (Answer each group "Yes" or "No" and check which)

a Apoplexy, Paralysis, Epilepsy, Loss of Consciousness, Dizziness, Nervous Breakdown , Headaches?

b Asthma, Pleurisy, Spitting Blood, Chronic Cough, Tuberculosis or other Lung Diseases

c High or Low Blood Pressure, Heart Disease, Angina Pectoris, Chest pains, Rheumatic Fever, Arthritis or any Bone Diseases?

d Stomach or Duodenal Ulcer, Appendicitis, Disease of Bowel, Liver, Gall Bladder or Spleen?

e Kidney Disease, Sugar in Urine, Blood in Urine, Kidney Colic or Stone, Diabetes?

f Syphilis or a Positive Blood Test, Tumor Cancer, Goiter, Dropsy or Anemia?

g X-ray, Electrocardiogram or Blood Studies? if so, give particulars.

h Any accident, injury, operations, medical advice or attention other than as stated above?

In regard to those answered "Yes", give full particulars below

Disease, Injury or Examination	Date	Details (No. of attacks, duration, severity and results)	Name and address of attending physicians

12 FOR WOMEN ONLY(single or married)

a. Date of last menstruation? _____ 20 ___

b. Are your menstruation irregular? ◯ Yes ◯ No

Details if answer is Yes _____

b. Are you pregnant? ◯ Yes _____ months ◯ No

If pregnant, check alternative desired:

◯ Pregnancy lien to be attached to Benefit Certificate

◯ Pay extra contribution of P5.00 per P1000 for one year

d. Date of last child delivery: _____ 20____

e. Any abdominal labors and pregnancies? ◯ Yes ◯ No

If yes, give the date and cause: _____

f. Have you ever aborted or miscarried? ◯ Yes ◯ No

If yes, give the date and cause: _____

g. Have you passed the menopause? ◯ Yes ◯ No

h. Have you ever had tumor or disease of the breast, uterus or ovaries? ◯ Yes ◯ No

If so, give details: _____

I do further declare and agree

a. That I have read the Part 2 of this application in its entirety and am fully acquainted with its contents and that each and every statement and answer made by me herein is true to the best of my knowledge and belief, and that all said statements shall in the absence of fraud be deemed representations and not warranties.

b. That if required by the Fraternity, I will promptly submit to one or more medical examinations in connection with this application.

c. That I hereby waive unless prohibited by law, on behalf of myself and my beneficiary or beneficiaries, the privileges and benefits of any and all laws of the Philippines which are now in force or which may hereafter be enacted, disqualifying any physician, nurse or other attendant from testifying in any action suit or proceeding as to any facts learned in the course of their professional employment and I consent, unless prohibited by law that any physician, nurse or other attendant may testify as to such facts in any action. suit or proceeding as fully and freely as though such law had not been enacted.

d. That failure to act or delay in action or failure to give or delay in giving to me or to the Association notice of any action upon this application shall not create any liability upon the part of the Fraternity.

Signed by me this _____ day of _____, 20____

Applicant's Signature: _____

(This must be signed by father or mother of applicant if he/she is below 18 years old)