COOPERATIVE INSURANCE SYSTEM OF THE PHILIPPINES
CISP Building, No. 80 Malakas St., Diliman, Quezon City
Tel. No. 4359128 Telefax 9230739
TIN 000-658-963

DETAILS OF HEALTH DECLARATION

In relation to your "Yes" answer in Health Questions or stated medical information on your insurance application form, please give supporting details such as:

1. Date of Birth _____ Age _____
2. Height ___ ft ___ in Weight ____ lbs or _____ kg
3. Are you a smoker? Yes or No? _____ No. of Sticks per day _____
4. Type of disease _____ Date acquired: _____
5. Surgical Operation/Treatment _____
6. Reason for Surgical Operation _____
7. Duration of disease _____
8. Date of Operation _____
9. Medications _____
10. Result/s _____
11. Recommendation/s _____
12. Name of Doctor _____
13. Contact Number/s _____
14. Name & Address of Hospital _____

I hereby declare that the above-mentioned information are true, complete and correct and shall form part and be the basis of the insurance application applied for.

Name of Applicant _____ Tel.# or CP# _____
Name of Cooperative _____
Signature and date signed _____

NOTE: Please complete the details of your declaration.

REFERENCE O.R.#/B.S.# _____

DATE OF UNDERWRITING LETTER _____