PROPOSED LIFE INSURED	Application No.
Name Last Name First Name Middle Name	
DETAILS OF THE HI RIDER APPLIED FOR	
HIR Plan Option: ☐ Plan A (without Surgical Cash Benefit) ☐ Plan B (with Surgical Cash Benefit)	
Daily Hospital Income Amount : _____	_____ Signature over Printed Name of Owner (if other than the Proposed Life Insured)

I/We hereby declare that all the statements and answers on all pages of this Rider application and any information supplied to the Company or to any Company's medical examiner if required, are complete, true and correct to the best of my/our knowledge and belief. I/We understand that all such statements and answers shall form part of the basis for the issuance of the insurance contract applied for. I/We further declare that this Rider is applied for under my/our Life Insurance application with the corresponding application number indicated in the upper right-hand corner of this form. Other details pertaining to my/our Life Insurance application are as indicated in the Application for Insurance (Part I).

I/We hereby understand and agree that:

1. This Rider shall become effective under the Basic Policy to which it is attached upon payment of the initial premium for this Rider and approval by the Company of this application.
2. The Daily Hospital Income Benefit, Daily Dread Disease Benefit, Daily Intensive Care Unit Benefit and Surgical Cash Benefit shall be due from the Company only upon receipt and approval of due proof of hospitalization and approval of the claim. Such payment shall be subject to the provisions, conditions and limitations of the said benefits while the Rider and the Policy to which it is attached are in force, if the Life Insured is hospitalized or confined and receives medical treatment arising from:

   a. illness or disease commencing after ninety (90) days from the effective date of this Rider or its last reinstatement; or
   b. accidental injury sustained after the effective date of this Rider.

3. The Illness or disease commencing within ninety (90) days from the effective date or from the last reinstatement date or the date of increase in benefits of this Rider shall be excluded from the payment of the benefit.

4. This benefit will not be payable if the hospital confinement shall result, either directly or indirectly, from any of the following causes:

   a. illness or disease commencing within ninety (90) days from the effective date of this Rider or from its last reinstatement date, whichever is later;
   b. treatment of Specific Illness during the first twelve (12) months from the effective date of the Rider or from its last reinstatement date, whichever is later;
      "**Specific Illness**" refers to any of the following illnesses and any related condition arising as a result thereof, irrespective of whether the Life Insured is aware of it or not;
      (i) Hernia of all types;
      (ii) All tumors, cysts and cancers;
      (iii) Endometriosis;
      (iv) Hemorrhoids;
      (v) Disease/Abnormalities of nasal septum/turbinates/sinus;
      (vi) Stone in urinary or biliary tracts/organs;
      (vii) Hypertension or cardiovascular disease;
      (viii) Gastric or duodenal ulcer;
      (ix) Diabetes mellitus.
   c. any period of hospital confinement wherein the entire confinement has not been recommended by a Physician;
   d. routine physical or any other examinations not incidental to the treatment of diagnosis of any injury, sickness or disease;
   e. any elective, cosmetic, reconstructive or plastic surgery unless necessitated by injury caused by an Accident,
   f. addiction to alcohol or drugs
   g. Acquired Immuno-Deficiency Syndrome (AIDS), AIDS related complex or infection by Human Immuno-Deficiency virus (HIV);
   h. pregnancy or resulting childbirth, abortion or miscarriage, birth control and infertility tests and/or any related complications as a result of any of the aforesaid conditions;
   i. sterilization of either sex, including but not limited to castration, vasectomy, tubectomy, and circumcision unless resulting from an infection;

j. any disease arising from congenital abnormalities;
k. psychotic treatment including but not limited to neuropsychosis, schizophrenia and others;
l. attempted suicide, whether the Life Insured is sane or insane;
m. treatment of pre-existing conditions as defined in the Definition of Terms Provision, unless Life Insured has been continuously covered for twelve (12) months from Effective Date or date of last reinstatement, and only for confinements after such continuous coverage;
n. murder or provoked assault;
o. poison, gas or fumes voluntary or involuntary taken even if resulting to homicide or murder
p. nuclear weapons, radiation or radioactivity from any device arising from the combustion of nuclear fuel and self sustaining process of nuclear fission;
q. dangerous sports (such as bungee jumping, martial arts, skateboarding, rollerblading, hang-gliding, windsurfing, mountaineering, rock climbing, bicycle racing, etc.).
r. any injuries incurred:
   (i) while on duty in any military, police, or fire fighting organization;
   (ii) in any brawl, riot, civil commotion, insurrection, war or any related incident;
   (iii) while committing a crime or any act punishable under special laws;
   (iv) while traveling in any form of air transportation, except if Life Insured is a paying passenger in a commercial airline on a scheduled passenger trip over its established passenger route.

Health Questions:

Have you ever had,

1. consulted, been confined, treated, undergone surgical operation or other form of medical attention not mentioned for any illness or injury? If yes, please provide ALL pertinent details including date/s, name/s of any attending physicians or hospitals in the space provided below. ☐ Yes ☐ No

_____

_____

_____

Have you ever had,

2. any diagnostic or laboratory tests like x-rays, ultrasound, blood tests, CT scans, MRIs, biopsy, or other tests not mentioned for purposes other than for routine employment? If yes, please indicate the specific diagnostic test/s taken, purposes, results and all other pertinent information below. ☐ Yes ☐ No

_____

_____

_____

I declare that the answers I have given are, to the best of my knowledge, true, correct and complete and that I have not withheld any material fact that may influence the assessment or acceptance of my application for insurance.

I agree that this form will be part of my application for insurance and that failure on my part to disclose any material fact known to me may cause the policy, when issued, to be rescinded.

Dated at _____this_____day of _____, _____.

_____ _____

Signature over Printed Name of the Proposed Life Insured

Signature over Printed Name of Owner (if other than the Proposed Life Insured)

Witnessed by:

_____

Signature over Printed Name of Soliciting Agent/Financial Advisor

NOTE: The answers given by the Proposed Life Insured or Owner in this Application will not guarantee the approval thereof in any way. The Company reserves the right to further evaluate the application and/or ask for additional information as it may deem necessary.

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

I hereby authorize -even abroad- any physician, hospital, clinic, insurance company or any other organization, institution or person that has any record of me and my health to give BDO Life Assurance Company, Inc., its Parent Company, its Trust Companies and Subsidiaries, any and all information about me with reference to my health, medical history, any hospitalization, advice, diagnosis treatment, disease or ailment. I also consent to a personal investigation. A photographic copy of this authorization shall be as valid as the original.

_____ _____

Proposed Life Insured

Applicant/Owner

_____ _____

Witnessed by Soliciting Agent/Financial Advisor

Date Signed