



INSURANCE COVERAGE INFORMATION

GROUP LIFE INSURANCE

Plan of Insurance: _____

Riders:

- Accidental Death & Dismemberment Benefit
Total & Permanent Disability Income Benefit
Critical Illness Benefit
Hospital Income Benefit
Terminal Illness Benefit
Others

CREDIT LIFE INSURANCE

Plan of Insurance: _____

Riders:

- Accidental Death & Dismemberment Benefit
Total & Permanent Disability Income Benefit
Critical Illness Benefit
Joint Life Insurance
Others

Policy Number

Effective Date

Participation Type Contributory Non-contributory

CLIENT INFORMATION

Name of Company/Group

Nature of Business

Business Address

Telephone No.

Fax No.

TIN:

SSS/GSIS No

Incorporation/ Registration No.

Source of Funds

Other Requirements

Pls. attach a certified true copy of your company's Articles of Incorporation / Partnership, general Information Sheet, List of Directors/Partners, List of Principal Stockholders owning at least 2% of capital stock

All statements, including those set forth on the attached sheet hereof, are true and complete to the best of my knowledge and belief and they shall form part of the contract for insurance. I understand and agree that no coverage will be in effect until this application is approved by the Company, the full amount due is paid, and a Policy is issued and delivered. Certificates will be issued and delivered during the lifetime and good health of the Proposed Employee/s.

Dated this ___ day of ___ in the year ___ at _____

Name & Signature of Company Representative

Designation

Name & Signature of Agent

Name of Unit Manager

Name of Agency Manager

Agent Code

Unit Manager Code

Agency Manager Code