

PLEASE CHECK DESIRED PLAN

<p><input type="checkbox"/> CLASSIC</p> <p>BASIC Accidental Death, Dismemberment, and Disablement (Includes Permanent and Total Disability)</p> <p>Optional Benefits</p> <p><input type="checkbox"/> Medical Expense Reimbursement-For Accident Only (AMR)</p> <p><input type="checkbox"/> Hospital Income Benefit - (For Accident Only) (HIB)</p> <p><input type="checkbox"/> Accident Weekly Income (AWI)</p> <p><input type="checkbox"/> Special Compassionate Benefit (SCB)</p> <p>Payment Mode</p> <p><input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual</p>	<p><input type="checkbox"/> JUNIOR CLASSIC</p> <p><input type="checkbox"/> PLAN 1 : Basic Only</p> <p><input type="checkbox"/> PLAN 2 : Basic with Medical Expense Reimbursement (For Accident Only)</p> <p><input type="checkbox"/> PLAN 3 : Basic with Hospital Income Benefit (For Accident Only)</p> <p><input type="checkbox"/> PLAN 4 : Basic with Medical Expense Reimbursement (For Accident Only) and Hospital Income Benefit (For Accident Only)</p> <ul style="list-style-type: none"> • Employees under the same level (Executive, Manager, Rank & File) should be enrolled under the same plan. • Payment mode is ANNUAL only.
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Name of Company/Group	
Business Address	
Telephone No.	
Fax Number	
TIN	
SSS/GSIS No	
Nature of Business	
Other Requirement(s)	<ul style="list-style-type: none"> • 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
Participation Type	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-Contributory

Check or cash for the amount due must accompany approved application.

Amount Paid with this application : _____ **OR Number/Date** _____

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 to the Assured. 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 _____.

Witnessed by:

Name & Signature of Agent	Personal Code	Agency
Name of Unit Manager	Personal Code	
Name of Agency Manager	Personal Code	
Name of Assured's Representative	Designation	Signature of Assured Representative

TO BE COMPLETED BY PHILAM LIFE ONLY

Policy No	Underwriter	Effective Date: Month Day Year	(PLEASE CREDIT PAYMENT TO ACCT 2605.2)
	Remarks		Basic Premium : _____ Doc Stamps : _____ Premium Tax : _____ TOTAL PREMIUM DUE : _____