CLIMBS LIFE AND GENERAL INSURANCE COOPERATIVE

CLIMBS Bldg., Zone 5, National Highway, Bulua, 9000 Cagayan de Oro City, Philippines
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MICRO INSURANCE

INDIVIDUAL APPLICATION FOR GROUP INSURANCE

Date Applied _____ (Group Yearly Renewable Term – GYRT-FIP)

Application No. _____

Name of Coop / Organization_____Plan__**GYRT-FAMILY INSURANCE PLAN (FIP)**_

Group Type _____ Option /Basic Coverage Amount _____

(Cooperative, other Self Help Group.)

(To be filled-out completely by the Principal-holder)

PERSONAL INFORMATION

Last Name:		**First Name:**			**Middle Name:**
Date of Birth (mm/dd/yyyy):	**Age:**	**Place of Birth**	**Gender** [ ]Male [ ]Female		**Civil Status** [ ]Single [ ]Married [ ]Widow [ ]Separated
Employment Type: [ ] Private [ ]Government [ ]Retirement [ ]Self-employed [ ]others_____					**Occupation:***(Present Job)*
Nationality	**Religion:**	**Height:**	**Weight:**	**Blood Type:**	**SSS/GSIS No.** [ ] YES [ ] NO
Present Address: **Permanent Address:**					**Contact No(s).:**

Co-insured Dependents to be included in the Plan *(Immediate family members only – use separate sheet if necessary)*	**Date of Birth / Age**	**Relationship**
1.		
2.		
3.		
4.		

Beneficiary(ies) to receive the Benefits:		Date of Birth	Relationship
(Primary)	1.		
(Secondary)	2.		

HEALTH DECLARATION FORM

Please answer each of the following questions in full disclosure/utmost good faith. Check in the box provided for details. Provide particulars if available (such as existing clinical records).

1. Are you aware of any health disorder or advice from doctor that you are suffering from any illness---------- [ ]YES [ ]NO
   If YES, please specify _____
2. Are you in good health and entirely free from any mental or physical impairment and/or deformities?----------[ ]YES [ ]NO
3. Have you ever been received or receiving disability benefit? ---------- [ ]YES [ ]NO
   If YES, please specify _____
4. Have you ever been diagnosed of cancer? ----------[ ]YES [ ]NO
5. Have you ever been diagnosed of HIV or AIDS? ---------- [ ]YES [ ]NO
6. Are you taking medication of any kind? If YES, for what? _____ [ ]YES [ ]NO
7. Please provide the name/address and the telephone number of your attending physician _____

I DECLARE, that the above answers are true and correct, and I agree that these shall be the basis of the issuance of Insurance for me under the Group Policy and that CLIMBS shall not be liable for any claims on account of illness, injury or death, the cause of which was known prior to approval of my request for insurance and withheld or concealed in the above statements. I hereby authorize any physician, doctors, hospital, clinic, that has any knowledge of my medical records to disclose when requested to do so by CLIMBS. **I UNDERSTAND that disqualification from coverage will entitle me only to refund of premium.**

"**DISCLOSURE:** In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud.

Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law.

DATA PRIVACY DISCLAIMER

By signing herein, you, the policy owner/ insurance applicant/ proposed insured, expressly consent for the lawful collection, processing, use, sharing, storage, retention or destruction and for other lawful or legal purposes, of all personal data pertaining to you in line with your application for life insurance policy and the servicing requirements thereof, in accordance with Republic Act No.10173 or the Data Privacy Act of 2012 and its Implementing Rules and Regulations.

CLIMBS Life and General Insurance Cooperative shall use this information with full regard to the provisions of the said law and its implementing rules and regulations, in connection with the necessary processes pertinent to the said insurance policy or application, or servicing thereof, and for other legitimate purpose or in compliance with government regulations, court orders, industry association, and in case authorized by law.

You shall hold the company free and harmless from any liability or expense that may arise from any transfer, disclosure, processing, collection, use, storage or destruction of the said information for activities done by CLIMBS Life and General Insurance Cooperative in regards your insurance application and servicing thereof in accordance with Republic Act No. 10173 or the Data Privacy Act of 2012 and its Implementing Rules and Regulations.

Signed at_____ this_____ day of_____20_____

_____ _____

Name & Signature of Authorized Officer *Name & Signature of Applicant Member*

Note: The insurance coverage of this plan will take effect upon receipt of payment & approval by CLIMBS and through the endorsement of the e.COC.