PHILPLANS FIRST INC.
14TH Floor, STI Holdings Center
6764 Ayala Avenue, 1226 Makati City

PRE-NEED APPLICATION FORM

This form must be filled out by the Planholder in **BLACK/BLUE INK.**
Write "N/A" if not applicable.

Proposal No.:

Plan Contract No.:

1. FULL NAME
First Name
Middle Name
Last Name
Extension

2. GENDER ○ Male ○ Female
3. HONORIFIC ○ Mr. ○ Mrs. ○ Ms. ○ Others
4. CIVIL STATUS ○ Single ○ Married ○ Widowed ○ Separated
5. NATIONALITY
6. MOTHER'S MAIDEN NAME

7. DATE OF BIRTH (MM/DD/YYYY)
8. PLACE OF BIRTH
9. GOV'T ISSUED ID PRESENTED (With Signature and Picture)
○ Passport ○ GSIS/SSS ○ PRC ○ License ○ Others

10. SOURCE OF INCOME
11. OCCUPATION
12. NAME OF EMPLOYER /BUSINESS
13. ESTIMATED ANNUAL INCOME

14. CURRENT ADDRESS (No., St., Brgy., City, Province, Country, ZIP)
15. PERMANENT ADDRESS (No., St., Brgy., City, Province, Country, ZIP)
○ Check if same as Current Address and no need to fill.
16. EMPLOYER/BUSINESS ADDRESS (No., St., Brgy., City, Province, Country, ZIP)

17. CONTACT INFORMATION
Telephone
Mobile
Email Address

18. SPOUSE (for married applicant)
Name
Date of Birth
Contact Information

19. BENEFICIARY/IES (If named beneficiary is below 18 years old, please include guardian)

	Full Name (Last Name, First Name, Middle Initial)	Date of Birth (MM/DD/YYYY)	Relationship to Applicant
PRIMARY			
SECONDARY			
GUARDIAN			
NOMINEE (For Education Plan)			

20. PLAN DETAILS
○ Memorial ○ Pension ○ Education
PLAN NAME
PACKAGE NAME
PAYMENT TERM
MATURITY TERM
EDUC PROGRAM
○ 5 YC ○ 4 YC ○ Others
○ WIB ○ NIB
HERITAGE LOT NO. (if any)
CONTRACT PRICE
IMSB/EDUC BENEFIT /MATURITY BENEFIT
OPTIONAL BENEFITS
Option 1
Option 2A
Option 2B
Option 2C
Others

21. MODE OF PAYMENT
○ Spot Cash ○ Annual ○ Semi-annual ○ Quarterly ○ Monthly
22. TOTAL INSTALLMENT AMOUNT
23. TOTAL GROSS CONTRACT PRICE

24. HEALTH INFORMATION

HEIGHT _____ ft/cm PRESENT WEIGHT _____ lbs/kgs

DETAILS TO **YES** ANSWERS

Include diagnosis, date, duration of illness, results of treatment or tests done and names/addresses of attending physicians and medical facilities.

Yes	No		
○	○	During the past years has the Applicant consulted any physician for medical treatment, had any laboratory or other diagnostic tests or sought medical advice for treatment or been confined in a hospital, clinic, or similar institutions?	
○	○	Has the Applicant ever taken habit-forming drugs, alcoholic drinks, or smoked cigarettes? (If YES, please specify and indicate amount/portions, frequency, and duration/length of time.)	
○	○	Does the Applicant have any abnormality or impairment in his health or physical condition?	
○	○	Has the Applicant ever engaged in motor sports, parachuting, underwater diving?	

25. FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) QUESTIONS

	Yes	No
Are you a U.S. Citizen?	○	○
Are you a tax resident of the U.S. because you hold a green card (permanent resident card)?	○	○
Are you a tax resident of the U.S. under the substantial presence test?	○	○

FOREIGN TIN/SSN _____

(To meet this test, you must be physical present in the United State for at least a) 31 days during the current year, and b) 183 days during the 3-year period that includes the current year and the two (2) years immediately before that counting: 1) All the days you were present in the current year, 2) 1/3 of the days you were present in the first year before the current year, and 3) 1/6 of the days you were present in second year before the current year.

26. DECLARATION AND SIGNATURE

1. All statements in this application shall form part of the contract between Philplans (the Company) and myself.
2. I am within the acceptable age for sustained insurability as specified in the Plan Contact.
3. I hereby authorize any entity or person to give the Company all information regarding my health and medical history solely for the purpose of assessing my fitness for insurance coverage. The Company shall maintain the strictest confidentiality in processing the same. A photographic copy of this authorization shall be valid as the original.
4. No coverage shall take effect without the written approval by the Company of my application.
5. I shall immediately notify the Company in writing of any change in: (a) **my residence, office, and/or mailing address;** (b) **my contact phone numbers and/or email address;** and (c) **my civil status or my designated beneficiary/ies.**
6. I agree that any notice from the Company provided to me through these channels shall be considered as official notice for enforcement of the Plan Contract and compliance with the applicable law, shall be effective and binding on me, and shall be conclusively deemed sufficient receipt by me of such notices. However, any error or discrepancy between the information transmitted via these channels and the official records of Philplans shall not in any way prejudice or give rise to any liability on the part of the Company.
7. I am solely responsible for maintaining the confidentiality, security, and integrity of access to the email address and the phone numbers that I have provided. The Company shall take reasonable security precautions for communicating through these channels buts shall not be liable for any interception which may occur beyond the reasonable control of the Company.
8. I hereby consent, without need of prior notification, to the processing, storage, and disclosure by the Company of all such personal and/or sensitive personal information in this form for the enforcement of my plan contract, and for all purposes deemed fit by the Company, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk management, underwriting and administration of insurance coverage and claims, data analytics and data sharing with the Company. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured. PhilPlans shall retain the information for the duration of your contract/business with it and for a reasonable time thereafter to comply with its legal obligations.
   I understand that as the owner of my data I may contact the Company at any time during normal business hours and exercise the following rights, among others: (a) to be informed of the type and extent of data in the Company's possession; (b) to have my data disposed of or deleted, subject to the legitimate need of the Company in order to fulfill its contractual obligations to me; (c) to correct or update my data as needed; and (d) to receive a copy of the data within a reasonable time upon request.
   I agree that the company may store the said data for the duration of the contract and a reasonable time thereafter.
   I understand that I may contact the Data Protection Officer of the Company for any concerns involving my data or privacy rights.
9. I agree that in the event that I am not eligible for insurance coverage, the Plan Contract may continue with No Insurance Benefit (NIB)
10. **I have fully read and understood the benefits and features of this Plan and agree to be bound by the provisions of the Plan Contract.**

	DATE	
SIGNATURE OVER PRINTED NAME	PLACE	Applicant's Right Thumbmark

27. SPECIMEN SIGNATURE OF APPLICANT

FOR PFI USE ONLY

I/We certify that I/we personally saw the Applicant and can attest to her/his legal identity, and he/she personally signed this application form. *(Indicate "N/A "on blank spaces)*

Signature of Sales Counsellor	PRINTED NAME	CODE	PRODUCTION CREDIT	CELLPHONE NUMBER

For Maturity Recapture

Plan Number _____

Planholder _____

Family Discount ○ Yes ○ No

Ref No. of 1st Plan _____

Total Amount Paid _____

OR Number _____

OR Date _____

Method of Payment ○ Cash ○ Check ○ Credit Card ○ Bank Payments

For Check Payment

Check Number		Depository Bank	
Date		Date/Time	
Branch		Depository Account Number	
Amount			