



# COCOLIFE

COCOLIFE Bldg., 6807 Ayala Ave., Makati City 1226  
MCC P.O. Box 1681 Tel. No. 812-9015 \* Fax No. 812-9053

APPLN. NO. \_\_\_\_\_

## APPLICATION FOR GROUP LIFE INSURANCE COVERAGE

### I. PERSONAL DATA

NAME : FIRST		MIDDLE		FAMILY	
DATE OF BIRTH	AGE	PLACE OF BIRTH		HEIGHT	WEIGHT
SEX	CIVIL STATUS		TIN	SSS & GSIS	
RESIDENCE ADDRESS					TEL. NO.
NAME OF EMPLOYER/RECRUITMENT AGENCY					TEL. NO.
OFFICE ADDRESS					
OCCUPATION OR TITLE/DESIGNATION			TERM OF EMPLOYMENT CONTRACT		

### II. BENEFICIARY (IES)

( ) Revocable ( ) Irrevocable NOTE: considered revocable if left unanswered

	NAME	AGE	RELATIONSHIP
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

### III. DECLARATION

I hereby represent and declare that:

- a. I am not below 18 years old and have not reached 65 years of age;
- b. I have not been advised of, treated for, or had any known indication of: high blood pressure, stroke, heart disease, chest pain, or other disorder of heart or blood vessels, asthma, TB or any chronic lung disease, ulcer or other digestive system disorder, bowel inflammatory disease, kidney problem, hepatitis or liver disease, diabetes, thyroid or other endocrine disorder, anemia, bleeding or other blood disorder, lupus, or other connective tissue disorder, paralysis, epilepsy or other neurologic disorder, cancer, mental or psychological problem, sexually transmitted disease, HIV or AIDS, alcoholism or drug abuse;
- c. I have not had any other physical, mental, or psychological illness / injury or impairment not mentioned above;
- d. I have not undergone any operation or hospitalization during the last five (5) years.

EXCEPTIONS: \_\_\_\_\_

I hereby agree that the above questions and answers shall be considered in lieu of a medical examination as part of my application for insurance. I hereby declare that all the foregoing answers and statements are complete, true and correct to the best of my knowledge and belief. I hereby agree that if there be any misrepresentation in the above statement material to risk, COCOLIFE shall have the right to reject and declare such insurance null and void.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Witnessed and verified by: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Authorized Representative \_\_\_\_\_

### IV. INSURANCE COVERAGE (TO BE FILLED UP BY insurance company)

AMOUNT OF COVERAGE \_\_\_\_\_

GROUP POLICY NO.: \_\_\_\_\_

NAME OF POLICYHOLDER: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

EXPIRY DATE: \_\_\_\_\_

PREMIUM: \_\_\_\_\_

OR NO.: \_\_\_\_\_

Approved: \_\_\_\_\_

Authorized Signatory \_\_\_\_\_

Atty Alfredo C. Tumacder, Jr.  
President