

INDIVIDUAL APPLICATION FORM

Group Micro Life Insurance Plan

Cooperative: _____ Product: () BLIP () CLIP / Membership: () New () Renewal

Applicant	Last Name First Name Middle Name					
Address						
Nationality		Civil Status		Gender		Tel. No.
Place of Birth				Birth Date		
Occupation (state duties)						
Source of Income			TIN			
GSIS / SSS / Drivers' License / Other ID No.						
Name of Beneficiary (ies)		Age	Relationship to Applicant			
<i>Note: If there are two (2) or more beneficiaries, proceeds shall be divided equally.</i>						

___ TPD COVERAGE: please check the coverage to be availed: ___ TPD10 ___ TPD30 ___ TPD50 ___ TPD80 ___ TPD100

___ HIB COVERAGE: please check the coverage to be availed: ___ HIB300 ___ HIB500

I hereby declare that I am/we are in good health and entirely free from any physical or mental impairment and that during the last five (5) years, I/we have not consulted or been treated or examined by a doctor for any disease or injury for more than two (2) weeks or been confined to a hospital for any length of time or had surgical operation before.

Thumbmark
if unable to sign

I hereby allow NATCCO Mutual Benefit Association, Inc. (NATCCO MBI) to utilize the information I supplied in this application as basis for any subsequent application for insurance coverage. I signify my consent and agree that NATCCO MBI: (a) may collect, use and disclose my personal data as provided in this document or obtained by NATCCO MBI as a result of being its member, for the purpose of processing this document and (b) may disclose and share the said information to its subsidiaries and/or affiliates, reinsurer or regulatory authorities. It should be understood that I have a right to revise the information that I have provided including the deletion of the given information in accordance with the Data Privacy Act of 2012 and the data protection policy of NATCCO MBI.

Dependent/s to be insured:

	NAME	Relationship to Applicant (spouse/parent/ child/sibling)	Birth Date	Age
Adult				
Minor				
Minor				
Minor				

Signature of Applicant

Date

CREDIT LIFE INSURANCE PLAN (CLIP)

LOAN DETAILS:

Loan amount: _____ Loan period: (no. of months) _____ Loan coverage (start & end date): _____

I hereby certify that the above information are all true and correct based on my knowledge. Moreover, I hereby accept the policies and guidelines of the NATCCO MBI.

For Branch Staff only

Share Capital		BLIP (Damayan) Contribution Amount	
Deposits		BLIP (Damayan) Period of Coverage	
Amount of Loan		O.R. / G.V. No.	
Term of Loan		Coop Code	

Prepared by: _____
Printed name over signature / designation

Approved by: _____
Printed name over signature / designation



NATCCO MBAI HEALTH QUESTIONNAIRE

Cooperative Name: _____

			Member-Borrower ☐	Date of Birth			
Last Name	First Name	Middle Name	Dependent ☐	mm/dd/yyyy	Age	Height	Weight

Please answer the following questions by checking the "Yes" or "No" box.

	YES	NO	Use this space or the reverse hereof to give full details, for item(s) with "Yes" answer. Indicate the date, symptoms, diagnosis, duration, treatment result, name of attending physician, name and address of hospital/clinic. All statements contained herein and all attachments hereto are hereby made part of this form.
A. Have you ever had medical consultation or treatment pertaining to:			
1. Brain or nervous system			
2. Lung or respiratory system			
3. Kidney or urinary system			
4. Heart or blood vessel			
5. Stomach or other abdominal organs			
6. Reproductive organs or breast			
7. Diabetes, cancer, tumor or blood diseases			
8. AIDS, HIV (Human Immuno-deficiency Virus) infection or a condition associated with either			
B. Have you ever had a positive blood test for AIDS or HIV infection?			
C. Have you ever had consultation, hospitalization or surgical operation due to any condition not mentioned above during the past 5 years?			
D. Have you had any mental impairment, physical defect, tumor or lump or abnormal growth in any part of your body?			
E. Have you ever had any major organ transplant?			
F. Have you ever had during the past 2 years:			
1. Loss of weight; dizzy spells; blood spitting; abnormality in breathing, urination or bowel movement; or unusual pain in any part of the body			
2. Medical examinations, X-ray, ECG, blood test or other diagnostic tests?			

I hereby certify that the above declarations are the most appropriate responses pertaining to my personal well-being. I understand that false information may be ground for contestability of insurance coverage. I further understand that the contestability period is within 6 months, from the effectivity of my insurance policy.

Date Signed

Signature of Member-Borrower/Dependent

Branch Manager

AUTHORITY TO CARRY PROXY VOTES

I, _____, of _____ having been enrolled and
(NAME OF MEMBER) (NAME OF PRIMARY COOP)
accepted as NATCCO MBA, Inc. member, do hereby authorize my primary cooperative to send delegates to carry their proxy votes to NATCCO MBA, Inc. including my proxy vote(s).

Date signed

Signature over printed name