InLife INSULAR HEALTH CARE
The HMO Subsidiary of Insular Life Assurance Company, Ltd.

InHealth PERSONA

APPLICATION FOR FAMILY PLAN

Application No. _____
Reference No. _____

PLEASE WRITE LEGIBLY IN BLOCK LETTERS. FILL OUT ALL BLANKS / BOXES OF THIS APPLICATION AND ITS ATTACHMENT, WHEN APPLICABLE, AND SUBMIT THEM TO INLIFE HEALTH CARE AS SOON AS POSSIBLE. ONLY COMPLETELY FILLED-OUT APPLICATIONS WITH OTHER DOCUMENTARY REQUIREMENTS, IF ANY, INCLUDING VALID IDENTIFICATION DOCUMENT (ID), WILL BE PROCESSED.

PART I – PRINCIPAL APPLICANT'S INFORMATION

LAST NAME**	FIRST NAME**	MIDDLE NAME	SEX (M/F)**

AGE**	BIRTHDATE (mm/dd/yyyy)**	PLACE OF BIRTH	HEIGHT**	WEIGHT**	CIVIL STATUS	NATIONALITY	RESIDENCE TEL. NO.	MOBILE NUMBER**

PRESENT ADDRESS** →I (NO. & STREET)	TOWN/BARANGAY	CITY/MUNICIPALITY	ZIP CODE

COMPANY NAME	OCCUPATION / POSITION	☐ SSS No. _____ or ☐ GSIS No. _____ or ☐ National ID No. for Non-Filipinos _____ ☐ Not applicable	TAX IDENTIFICATION NUMBER** _____ Not Applicable. Reason: ☐ Nonresident Alien*** ☐ Student with no TIN
COMPLETE BUSINESS ADDRESS →I	E-MAIL ADDRESS** OFFICE TEL. NO.		

PART II – INFORMATION ON THE AGREEMENT

PROGRAM TYPE →I	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, including *top 6 Hospitals	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, excluding *top 6 Hospitals	❑ LUZON ACCESS – Open Access to all Accredited Hospitals and Clinics in Luzon (except NCR)	❑ VISMIN ACCESS – Open Access to all Accredited Hospitals and Clinics in Visayas and Mindanao

** Asian Hospital and Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center (QC and BGC) and The Medical City*

ROOM ACCOMMODATION	❑ SUITE	❑ PRIVATE	❑ SEMI-PRIVATE	❑ WARD	DENTAL COVERAGE (Optional Benefit)	❑ YES	❑ NO
MODE OF PAYMENT	❑ ANNUAL						

PART III – A. FIRST DEPENDENT'S PERSONAL AND AGREEMENT INFORMATION

LAST NAME**	FIRST NAME**	MIDDLE NAME	SEX (M/F)**

AGE**	BIRTHDATE (mm/dd/yyyy)**	PLACE OF BIRTH	HEIGHT**	WEIGHT**	CIVIL STATUS	NATIONALITY	MOBILE NUMBER**	E-MAIL ADDRESS**

RELATIONSHIP WITH PRINCIPAL APPLICANT	OCCUPATION	☐ SSS No. _____ or ☐ GSIS No. _____	TAX IDENTIFICATION NUMBER

PROGRAM TYPE →I	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, including *top 6 Hospitals	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, excluding *top 6 Hospitals	❑ LUZON ACCESS – Open Access to all Accredited Hospitals and Clinics in Luzon (except NCR)	❑ VISMIN ACCESS – Open Access to all Accredited Hospitals and Clinics in Visayas and Mindanao

** Asian Hospital and Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center (QC and BGC) and The Medical City*

ROOM ACCOMMODATION	❑ SUITE	❑ PRIVATE	❑ SEMI-PRIVATE	❑ WARD	DENTAL COVERAGE (Optional Benefit)	❑ YES	❑ NO

PART III – B. SECOND DEPENDENT'S PERSONAL AND AGREEMENT INFORMATION

LAST NAME**	FIRST NAME**	MIDDLE NAME	SEX (M/F)**

AGE**	BIRTHDATE (mm/dd/yyyy)**	PLACE OF BIRTH	HEIGHT**	WEIGHT**	CIVIL STATUS	NATIONALITY	MOBILE NUMBER**	E-MAIL ADDRESS**

RELATIONSHIP WITH PRINCIPAL APPLICANT	OCCUPATION	☐ SSS No. _____ or ☐ GSIS No. _____	TAX IDENTIFICATION NUMBER

PROGRAM TYPE →I	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, including *top 6 Hospitals	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, excluding *top 6 Hospitals	❑ LUZON ACCESS – Open Access to all Accredited Hospitals and Clinics in Luzon (except NCR)	❑ VISMIN ACCESS – Open Access to all Accredited Hospitals and Clinics in Visayas and Mindanao

** Asian Hospital and Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center (QC and BGC) and The Medical City*

ROOM ACCOMMODATION	❑ SUITE	❑ PRIVATE	❑ SEMI-PRIVATE	❑ WARD	DENTAL COVERAGE (Optional Benefit)	❑ YES	❑ NO

PART III – C. THIRD DEPENDENT'S PERSONAL AND AGREEMENT INFORMATION

LAST NAME**	FIRST NAME**	MIDDLE NAME	SEX (M/F)**

AGE**	BIRTHDATE (mm/dd/yyyy)**	PLACE OF BIRTH	HEIGHT**	WEIGHT**	CIVIL STATUS	NATIONALITY	MOBILE NUMBER**	E-MAIL ADDRESS**

RELATIONSHIP WITH PRINCIPAL APPLICANT	OCCUPATION	☐ SSS No. _____ or ☐ GSIS No. _____	TAX IDENTIFICATION NUMBER

PROGRAM TYPE →I	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, including *top 6 Hospitals	❑ NATIONWIDE ACCESS – Open Access to all Accredited Hospitals and Clinics, excluding *top 6 Hospitals	❑ LUZON ACCESS – Open Access to all Accredited Hospitals and Clinics in Luzon (except NCR)	❑ VISMIN ACCESS – Open Access to all Accredited Hospitals and Clinics in Visayas and Mindanao

** Asian Hospital and Medical Center, Cardinal Santos Medical Center, Makati Medical Center, St. Luke's Medical Center (QC and BGC) and The Medical City*

ROOM ACCOMMODATION	❑ SUITE	❑ PRIVATE	❑ SEMI-PRIVATE	❑ WARD	DENTAL COVERAGE (Optional Benefit)	❑ YES	❑ NO

NOTE: YOU MAY USE AN ADDITIONAL SHEET FOR DEPENDENTS (IF NECESSARY)

PART IV – INFORMATION ON THE PAYOR / LEGAL GUARDIAN [To be filled-out only if the applicant is not the payor or the applicant is a minor]****

LAST NAME**	FIRST NAME**	MIDDLE NAME	SEX (M/F)

COMPANY NAME (if Company paid*****) / BUSINESS NAME	CONTACT PERSON & POSITION TITLE	TIN (Company/Payor/Legal Guardian)**

PAYOR / LEGAL GUARDIAN COMPANY ADDRESS →I NO. & STREET	TOWN/BARANGAY	CITY/MUNICIPALITY	ZIP CODE

RELATIONSHIP TO APPLICANT	RESIDENCE TEL.NO.	MOBILE NUMBER**	OFFICE TEL. NO.**	E-MAIL ADDRESS**

PART V – SOURCE OF FUNDS (Check all that apply)

PRINCIPAL / PAYOR Name of Employer/Business

☐ SALARY ☐ PENSION ☐ REMITTANCES ☐ COMMISSIONS ☐ OTHERS _____ ☐ BUSINESS _____

PART VI – BILLING ADDRESS

Deliver Billing Notices to my: ☐ RESIDENCE ☐ OFFICE ☐ EMPLOYER/PAYOR ☐ LEGAL GUARDIAN

☐ I PREFER PAPERLESS BILLING Paperless Billing is the smart and ecological choice, and we encourage you to use it. But if you ever need a paper copy of your bill, you can make that request easily.

*Scanned or photocopy of one (1) official Identification document of the Applicant and the Payor must be submitted (e.g. Passport, Driver's License, PRC ID. Please refer to ' Valid Identification Cards for Financial Transactions' under BSP Circular No. 608, s. 2008). **Required field ***Must not derive any income in/from the Philippines. If deriving income, please secure TIN as required by Philippine laws. Whether or not deriving income in the Philippines, please provide scanned or photocopy of passport, stamp of last arrival and Philippine visa/ work permit (if applicable). ****For Guardians, submit Judicial Declaration of Guardianship or Affidavit of Guardianship as the case may be, and other proof of Actual Care and Custody of the minor. *****If company paid, please provide Corporate Surety and scanned or photocopy of one (1) official Identification document of the Signatory.

PART VII – LIFE (GROUP TERM) INSURANCE

DESIGNATION OF BENEFICIARIES:

- The **PRIMARY (P)** beneficiary shall receive the death benefit should the insured individual die ahead of him/her. A PRIMARY beneficiary may be designated as REVOCABLE or IRREVOCABLE beneficiary.
- If the beneficiary designation is **IRREVOCABLE (I)**, the insured individual cannot change the beneficiary nor exercise any right under the policy without the consent of the irrevocable designated beneficiary.
- If the primary beneficiary is designated as **REVOCABLE (R),** the insured individual may exercise all his rights under the policy without the consent of the designated revocable beneficiary.
- The **CONTINGENT (C)** beneficiary shall receive the death benefit should all the Primary beneficiaries die before the insured individual. A Contingent beneficiary designation is considered as revocable.
- If the insured individual fails to indicate the designation of his/her beneficiaries, default designation will be "Primary" and "Revocable".
- Unless otherwise stated, the primary beneficiaries shall share equally in the insurance proceeds.
- For minor beneficiaries, the representative of the minor beneficiary must secure and submit a court-approved Affidavit of Legal Guardianship.

NAME OF BENEFICIARIES[3] (Surname, First Name, Middle Initial)	**Sex**	**Designation** (Please read the notes above before ticking off the boxes below)		**Relationship with Applicant**	**Birthdate** (mm/dd/yyyy)	**Age**	**Exact Amount / Percentage of Sharing** (Optional)
		☐ P ☐ R ☐ I	☐ C				
		☐ P ☐ R ☐ I	☐ C				

[3] The following are recommended beneficiaries: spouse, son/daughter, parent, brother/sister

AUTHORIZATION. I hereby authorize any person, organization or entity that has any record or knowledge of my health and/or that of my Dependents/Secondary Members to give to Insular Health Care, Inc. ("InLife Health Care") any or all of such records or information in his/her/its possession. These include, but is not limited to, records or information relating to any medical examination, consultation, diagnosis, hospitalization, treatment or availment of other healthcare services. I also authorize InLife Health Care to process my personal and sensitive personal information in accordance with its Data Privacy Policy, including its subsequent amendments, as published in its website: **https://www.insularhealthcare.com.ph/privacy-policy/**. I am aware that should I have any privacy concern regarding my personal data, I may consult InLife Health Care's Data Protection Officer at **dataprivacy@insularhealthcare.com.ph** or Tel: 813-0131 loc 8505, or the National Privacy Commission at **https://privacy.gov.ph**

I understand that the consent I am giving through this form is in addition to any other consent that I may have already given InLife Health Care. and its affiliates regarding the processing of my personal data. I further understand that the consent I have given shall remain in full force until revoked in writing except to the extent that action has already been taken based therein. I hereby release InLife Health Care, its affiliates and partners from any liability arising from any disclosure and/or processing made in accordance with the consent I have given. A photographic copy of this authorization shall be as valid as the original.

[Maaaring humingi ng tulong kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

_____	_____	_____	_____
Printed Name & Signature of Principal Applicant	Date Signed	Printed Name & Signature of Employer (If Company paid)	Date Signed

PART VIII – QUESTIONNAIRE

		YES	NO
1.	Are all members actively at work on a regular full-time basis or actively performing daily normal activities of life?	☐	☐
2.	Is any member engaged in any hazardous sport or avocation?	☐	☐
3.	Is any member presently covered under any hospitalization or medical plan?	☐	☐
4.	Has any member ever been rejected for insurance, including healthcare plans, or been offered insurance at a higher or rated premium?	☐	☐
5.	Has any member had any deferment, rejection, or discharge from any outfit because of any physical or mental condition?	☐	☐
6.	Does any member have any physical abnormality such as lumps or growths on any part of the body, impairment of sight or hearing, loss of any part of the body, or other physical defects?	☐	☐
7.	During the past years, has any member:		
	a. Consulted, been treated or operated on by a physician or medical practitioner?	☐	☐
	b. Had any medical examination or check-up?	☐	☐
8.	Has any member ever been confined in any hospital or clinic for medical treatment or surgical operation?	☐	☐
9.	Has any member ever consulted or been treated for high blood pressure, heart trouble, diabetes, cancer, liver disease, asthma or peptic ulcer?	☐	☐
10.	Is any member taking any regular medication or undergoing medical treatment or observation?	☐	☐
11.	For women only (indicate first name, and answer):		
	a. Date of last menstrual period: _____		
	b. Date of last delivery: _____		
	c. Is any member pregnant? If yes, state number of months: _____	☐	☐
	d. Has any member ever delivered by caesarian section or experienced any abnormality in her pregnancy?	☐	☐

Please explain fully a "NO" answer to Question 1 and any "YES" answer to Questions 2-11 above. You may use the extra space on the next page or a separate sheet, if needed.

Please indicate details of all known illnesses/injuries. Only health conditions declared in the application shall be covered; provided that, these conditions are not part of the permanent exclusions to the program or these are not otherwise illnesses/injuries excluded in the underwriting process of your application. Genuinely unknown (and therefore undeclared) health conditions will be evaluated for possible consideration; provided that, these are not concealment cases. Any information contained herein shall be considered final.

Q1-Q6

(Q7-Q11) Chief Complaints and Diagnosis (Indicate together with First Name of Person with Complaint/ Diagnosis)	Date, Duration, Treatment and Results	Name and Address of Physician and Hospital

Home Office Endorsement

Does any member have any existing HMO carrier, group hospital plan or self-insured policy? ❑ Yes ❑ No
If yes, please specify: _____ Duration of Membership. _____
Submitted Data Identification (ID) Type: _____ Number: _____
Issuing Authority: _____ Place of Issue: _____ Date of Expiration/Validity: _____

DECLARATION. We hereby declare and agree that all statements and answers contained herein and in any accompanying document (including the Summary of Benefits) are full, complete and true, and bind all parties in interest under the agreement herein applied for. We understand that payment and receipt of any amount does not constitute acceptance of application and that there shall be no contract of health care coverage unless and until an agreement is issued on this application and a deposit for the full membership fee according to the mode of payment applied for is actually paid while we are in good health and during our lifetime. We understand that any concealment or misrepresentation relating to any material fact shall render the health care coverage and life (group term) insurance null and void.

We also declare that we had been briefed on the salient features as well as the benefits and limitations of the InLife Health Care Program. We accept the InLife Health Care Program as contained herein and in other accompanying documents (including the Summary of Benefits), and we agree to its terms and conditions. We are aware that no information acquired by any representative of InLife Health Care shall be binding upon said company unless set out in writing in this application; that any physician is hereby expressly authorized to disclose or give testimony at any time relative to any information acquired by him/her in his/her professional capacity, upon any question affecting our eligibility for health care coverage; provided that, in case of failure by such physician or any entity to furnish said information despite our authorization, we hereby undertake to personally facilitate acquisition of the same to expedite the evaluation of our application. We further declare that our acceptance of any agreement issued on this application shall be a ratification of any correction, in addition to this application, as stated in the space for Home Office Endorsement.

CONFIRMATION OF AUTHORIZATION (FOR DEPENDENTS). We hereby confirm and grant the same authorization regarding the access of our medical records and information, and the processing of our personal data as that made by the principal applicant (page 2 of this application).

TERMS AND CONDITIONS. 1. The proposed members must be in good health and medically acceptable to InLife Health Care (under the company's underwriting rules) on the date of application and on the date of the coverage applied for is issued. 2. As a pre-requisite to processing this application, it is important that the proposed members should make a deposit equal to at least a full modal membership fee for the basic health care coverage and any other benefits applied for. Any excess deposit shall be held for the proposed members subject to their instructions. The deposit may be in cash. If made through a check or a bank draft, it shall be considered valid only if honored on first presentation of payment. All payments are treated as deposits only until the Agreement is issued to the proposed members. Should any of these terms and conditions not be met, no health care coverage shall be in force and the proposed members' deposit shall be returned.

IMPORTANT NOTICE 1. Payment of the proposed members' deposit should be made at the Head Office, at any of the InLife Health Care branch offices nationwide or to a bona fide agent (whose provisional receipt will be replaced with an official receipt upon remittance to the Head/Branch Office of InLife Health Care). If within ten (10) days after payment has been made and the proposed members do not receive their official receipt, the proposed members should notify the company immediately. Payment can also be made through bank deposit or fund transfer into the bank account of InLife Health Care. 2. As stated above, a 'Summary of Benefits' forms part of this agreement wherein the proposed members should certify their acceptance of the product features and the terms and conditions of the InLife Health Care Program, and submitted to InLife Health Care together with this application.

[Maaaring humingi ng tulong kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]

_____ Printed Name & Signature of Applicant/ Date	_____ Printed Name & Signature of Dependent/ Date	_____ Printed Name & Signature of Dependent/ Date	_____ Printed Name & Signature of Dependent/ Date
_____ Printed Name & Signature of Dependent/ Date	_____ Printed Name & Signature of Dependent/ Date	_____ Printed Name & Signature of Dependent/ Date	_____ Printed Name & Signature of Dependent/ Date

Additional Notes:

AGENT'S CONFIDENTIAL REPORT

1. I am ☐ **aware**/ ☐ **not aware** of any information on the health, habits or reputation of the applicant, which is not disclosed in this application, and which may have a bearing on the risk to be undertaken by the Company. (If aware, please state information: _____).
2. I ☐ **personally saw the applicant**/ ☐ **did not personally see the applicant** and I ☐ **personally asked each question** from the applicant exactly as set forth in this application and personally recorded the answers exactly as how they were given to me/ ☐ **did not** personally ask the question from the applicant/ ☐ **did not** ask each question exactly as set forth in this application/ ☐ **did not** personally record the answers ☐ **did not** record the answers exactly as how they were given to me. (In case of any answer in the negative, please explain why: _____).
3. I personally briefed the applicant on the salient features as well as the benefits and limitations of the InLife Health Care Program.
4. I understand that any misdeclaration or falsity in my declarations may result in the termination of my Agency Agreement and/or the forfeiture of any commission or payment due me. I hereby consent to be solidarily liable with InLife Health Care for any damage, liability, expense, claim or judgment arising out of or in connection with such misdeclaration or falsity.

_____	_____	_____	_____
Printed Name & Signature of Agent/ Date	Agent's Code	Printed Name & Signature of Agency Leader/ Date	Agency Leader's Code

FOR HOME OFFICE USE ONLY		
FOR CASHIER	FOR MEDICAL UNDERWRITING	FOR BENEFIT PLAN ADMIN./ CUSTOMER RELATIONS

INSULAR HEALTH CARE, INC.
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