ARMED FORCES AND POLICE MUTUAL BENEFIT ASSOCIATION, INC.
Col Bonny Serrano Ave cor EDSA, Camp Aguinaldo, Quezon City
Contact Nos. (02) 8822-MBAI (6224) Website: www.afpmbai.com.ph
Email: mail@afpmbai.ph Facebook: @AFPMBAIOfficial

MBAI iPROTEK APPLICATION FORM

MEMBER INFORMATION:

LAST NAME		HEIGHT	
FIRST NAME		WEIGHT	
MIDDLE NAME		MOBILE NO.	
EXTN/SUFFIX (Sr., Jr., III, etc.)		EMAIL	
GENDER		TIN	
CIVIL STATUS		SSS/GSIS	
PLACE OF BIRTH		RANK	
DATE OF BIRTH (mm/dd/yy)		BRANCH OF SERVICE	
NATIONALITY		UNIT ASSIGNMENT	
POSITION/OCCUPATION		SERIAL/ACCOUNT NO.	

RESIDENCE ADDRESS

House/Room/Bldg. No. | Street/Subdivision | Brgy/Sitio/Purok/Barrio

Municipality/Town/City | Province | Zip Code

SOURCE OF INCOME _____ MONTHLY INCOME _____

DESIGNATED BENEFICIARIES: (All Beneficiaries are deemed revocable unless stated in this form)

NAME	DATE OF BIRTH/AGE	RELATIONSHIP	% SHARE

AUTOMATIC CONTRIBUTION LOAN

If any contribution for insurance remains unpaid at the end of the grace period, and the member's Equity Value is sufficient, such contribution shall be paid from the member's Equity Value. Such payments will be considered as loan against the member's Equity Value.

HEALTH STATEMENTS

1. Have you ever been sick for the past five (5) years? If yes, please identify type of sickness.	Y ☐	N ☐	
2. Ever had any accident, operation or medical advise within the past five (5) years?	Y ☐	N ☐	
3. Do you have any disability or deformity? If yes, please indicate.	Y ☐	N ☐	

DECLARATION AND AUTHORIZATION / PRIVACY NOTICE AS PER REPUBLIC ACT 10173 & REPUBLIC ACT 9510

I hereby state and declare that all the answers contained herein are true, complete and correct to the best of my knowledge and belief, and shall form part of my application for insurance. It is understood and agreed that this insurance coverage shall take effect on the first day of the month for which the payroll deduction is made, if the payment is made thru Automatic Salary Deduction or the actual date of payment of first contribution, if directly paid to AFPMBAI.

I accept, agree with, and understand that all personal information supplied herein will be used for internal purposes and will not be released to third parties outside of AFPMBAI without my expressed consent. I waive my rights under applicable data privacy laws. I further agree to receive announcements, information, and promotional messages through various communication channels from the Association.

_____
INSURED'S SIGNATURE

_____
DATE SIGNED

FOR AFPMBAI USE ONLY

RECOMMENDED BY: _____ APPROVED BY: _____

CODE NO.: _____ DATE APPROVED: _____

ADDITIONAL INFO SHEET A
(For Internal Purposes Only)

PLEASE PUT A CHECK MARK (✓) BESIDE THE PREMIUM OF THE DESIRED PLAN

PACKAGE	Plan 99	Plan 199	Plan 499	Plan 999
Applicable to	Barangay Tanods	■ Reservists, Security Guards, CAFGUAA, Coast Guard Auxilliary, PDEA, SCAA, NBI, Bureau of Immigration, NAM RIA, Airport Police, Customs Police, and other uniformed service units ■ Spouse, parents, and children of Regular Members ■ Cadets and graduates of PMMA, PNPA and MAAP ■ Employee Group; Accredited IRs/FAMs	Retired Enlisted Personnel	Retired Officers
MODAL CONTRIBUTION				
MONTHLY	☐ Php 99.00	☐ 199.00	☐ 499.00	☐ 999.00
QUARTERLY	☐ Php 290.00	☐ 582.00	☐ 1,460.00	☐ 2,922.00
SEMI-ANNUAL	☐ Php 568.00	☐ 1,142.00	☐ 2,863.00	☐ 5,732.00
ANNUAL	☐ Php 1,114.00	☐ 2,239.00	☐ 5,614.00	☐ 11,239.00
AMOUNT OF INSURANCE	**Php 63,643.00**	**127,929.00**	**320,786.00**	**642,214.00**

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Death Benefit	100% of Amount of Insurance
Accidental Death Benefit	100% of Amount of Insurance
Killed-In-Action Benefit	50% of Amount of Insurance
Member's Equity Value	50% of Total Contribution + Interest
DISABILITY/DISMEMBERMENT BENEFIT	
LOSS OR LOSS OF USE OF:	
Both Hands or Both Feet	100% of Amount of Insurance
Sight of Both Eyes	100% of Amount of Insurance
One Hand and One Foot	100% of Amount of Insurance
Either Hand or Foot and Sight of One Eye	100% of Amount of Insurance
Either Hand or Foot or Sight of One Eye	50% of Amount of Insurance
Hearing of Both Ears	50% of Amount of Insurance
Four Fingers	35% of Amount of Insurance
Hearing of One Ear	25% of Amount of Insurance
All Toes on One Foot	25% of Amount of Insurance
Thumb	15% of Amount of Insurance
Index Finger	10% of Amount of Insurance
Middle Finger	6% of Amount of Insurance
Ring Finger or Big Toe	5% of Amount of Insurance
Little Finger	4% of Amount of Insurance
Metacarpals 1st or 2nd (Additional)	3% of Amount of Insurance
Metacarpals 3rd, 4th, or 5th (Additional)	2% of Amount of Insurance
Any Toe Other Than Big Toe, Each	1% of Amount of Insurance

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AUTHORIZATION TO DEDUCT

DATE: _____

TO : FINANCE/DISBURSING OFFICER

I hereby authorize the Finance/Disbursing Officer to deduct from my salary the amount of_____ representing my monthly contribution for the MBAI iProtek and remit the same to the ARMED FORCES AND POLICE MUTUAL BENEFIT ASSOCIATION, INC. (AFPMBAI) effective immediately. In the event that my present Net Take Home Pay (NTHP) is insufficient to cover the monthly contribution, I also authorize my Finance/Disbursing Officer to effect the said deduction immediately as soon as my NTHP is sufficient enough to accommodate it. I further authorize AFPMBAI to access my personal information under my Unit/Office electronic payroll system.

This Authorization shall not relieve me from the responsibility of ensuring that the required deductions are made from my salary and promptly remitted to AFPMBAI when and as they become due. This authority shall terminate only upon my separation from the active service.

PRIVACY NOTICE AS PER REPUBLIC ACT NO. 10173

AFPMBAI upholds an individual's data privacy rights and observes that all personal information, sensitive personal information and privileged information collected and to be collected are processed or recorded, managed, organized, stored, updated, retrieved, consolidated, used, blocked, and erased according to the Data Privacy Act of 2012 (RA 10173), its Implementing Rules and Regulations (IRR), and various Circulars under the principles of transparency, legitimate purpose, and proportionality.

I hereby give my consent to the processing, sharing, and/or transferring of my personal data relating to my account/s, without notice, to AFPMBAI, its service providers and entities or third parties having authority or right to such disclosure of information as in the case of regulatory agencies, governmental or otherwise, which have required such disclosure from AFPMBAI, also to enable AFPMBAI to service my account/s, to provide all existing features and future enhancements thereto, and to avail other AFPMBAI products, services, facilities and channels as the AFPMBAI deems necessary. I agree to hold AFPMBAI, its affiliates, subsidiaries and third party service providers free and harmless from any liability arising from or in connection with the consent herein given.

PLEASE PRINT ALL INFORMATION LEGIBLY.

BRANCH OF SERVICE: _____

_____	_____	_____	_____	_____
RANK	*(LAST NAME, FIRST NAME, MIDDLE NAME)*	*SERIAL/ACCOUNT NO.*	*SIGNATURE*	*TIN*

_____	_____	_____	_____
UNIT ASSIGNMENT	*DATE OF BIRTH (MM/DD/YYYY)*	*MOBILE NO.*	*EMAIL ADDRESS*

Submitted by: _____ **Transmittal No.:** _____
Signature over Printed Name / SOLCODE / FAMCODE *(for SSS use only)*

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BRANCH OF SERVICE: _____

_____	_____	_____	_____	_____
RANK	*(LAST NAME, FIRST NAME, MIDDLE NAME)*	*(SERIAL/ACCOUNT NO.)*	*SIGNATURE*	*TIN*

_____	_____	_____	_____
UNIT ASSIGNMENT	*DATE OF BIRTH (MM/DD/YYYY)*	*MOBILE NO.*	*EMAIL ADDRESS*

Submitted by: _____ **Transmittal No.:** _____
Signature over Printed Name / SOLCODE / FAMCODE *(for SSS use only)*

ver.June2024