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

APPLICATION FOR INSURANCE

Application No.:

ANSWER EACH QUESTION COMPLETELY. PRINT OR TYPE YOUR ANSWER. CHECK APPROPRIATE BOXES.

1. a. Who is applying for this insurance? ☐ Person to be insured ☐ Payor

PERSON TO BE INSURED	**Payor** if insured is not the Payor
b. Name Last Name First Name Extn. Name Middle Name	Last Name First Name Extn. Name Middle Name
c. Organization ☐AFP/PNP/BFP/BJMP/PCG ☐Others (Specify)	☐AFP/PNP/BFP/BJMP/PCG ☐Others (Specify)
d. Rank SN BR of SVC	Rank SN BR of SVC
e. Address (Check mailing address) ☐ Residence _____ Tel. No. _____ ☐ Unit/Business Tel. No.	
f. Civil Status ☐Single ☐Married Sex ☐Male ☐Widow ☐ Legally Separated ☐Female	Civil Status ☐Single ☐Married Sex ☐Male ☐Widow ☐ Legally Separated ☐Female
g. Date of Birth Age	Date of Birth Age
h. Place of Birth Nationality	Place of Birth Nationality
i. Occupation(s) Contact Number	Occupation(s) Contact Number
j. Other source of income/fund TIN:	Other source of income/fund TIN:

2. a. Relationship of Payor to person to be insured If Insured is not the Payor

b. Contingent Payor (If any, upon death of Payor) Relationship to person to be insured Age
Name

3. a. Amount of Insurance	b. Mode of Premium Payment		c. Amount of Premium
	☐Monthly ☐Semi-Annually ☐Quarterly ☐Annually	☐Payroll Deduction ☐Direct payment	P

4. a. Plan of Insurance ☐ Participating ☐ Non-Participating

b. Dividend Option for Participating Plan
(Unless otherwise indicated, Option 3 is automatically assumed)
☐1. Paid in Cash ☐3. Left to Accumulate with Interest
☐2. Applied to any premium due ☐4. Applied as Paid-up Additional Insurance

5. Supplementary Benefits
Payor_____ Years_____ ☐ADB_____ Others (Specify): ☐_____ ☐_____

6. Other Insurance in Force on Life of

Person to be Inusred				Payor			
Insurance Company	Amount of Insurance		Year Insured	Insurance Company	Amount of Insurance		Year Insured
	Life	Accident			Life	Accident	

7. Beneficiary/Beneficiaries

A. Primary

Name	Age	Place of Birth	Sex (M/F)	Relationship to person to be insured	Nationality	Contact No. (leave blank if same with Insured)	Address (leave blank if same with Insured)

B. Contingent

Name	Age	Place of Birth	Sex (M/F)	Relationship to person to be insured	Nationality	Contact No. (leave blank if same with Insured)	Address (leave blank if same with Insured)

The above named beneficiary/beneficiaries is/are: (Unless otherwise indicated, Option 1 is automatically assumed) ☐1. Revocable ☐2. Irrevocable

Note: A. If person to be insured is under age 18, the Payor must sign this Application and must be named as Primary Beneficiary.
Any other Beneficiary/ies must be named as Contingent Beneficiary/ies.
B. If more than one beneficiary is named in any class, equal shares shall be assumed unless otherwise indicated in special instructions.

8. PREMIUM DEFAULT OPTION (Unless otherwise indicated, Option 3 is automatically assumed)

☐ 1. Premium Loan ☐ 2. Net Surrender Value ☐ 3. Paid-up Insurance ☐ 4. Extended Term Insurance

✓ DECLARATIONS REGARDING PERSON TO BE INSURED (AND IF PAYOR BENEFIT IS APPLIED FOR)

9. Has the person to be Insured/Payor	Person to be insured		PAYOR	
	YES	NO	YES	NO
a. ever flown in an aircraft than as a passenger?				
b. ever owned or ridden a motorcycle, or engaged in auto or motorboat racing, skydiving or other hazardous avocation?				
c. ever had insurance or reinstatement of insurance on his life declined, postponed, or modified in amount, plan or rate?				
10. Present weight ( ) kgs. ( ) lbs. Present height ( ) cm. ( ) ft/in.				
11. Has the Person to be Insured/Payor				
a. ever used alcoholic beverages to excess, taken habit-forming drugs or sought advice to treatment for alcoholism, drug habit or other addiction?				
b. ever had medical consultation or treatment pertaining to:				
(1) brain or nervous system?				
(2) lungs or respiratory system?				
(3) kidney or urinary system?				
(4) heart or blood vessels?				
(5) stomach or other abdominal organs?				
(6) impairment of sight or hearing, lameness, disability or deformity?				
(7) reproductive organs or breast?				

	Person to be insured		PAYOR	
	YES	NO	YES	NO
(8) diabetes, cancer, tumor or blood disease?				
(9) AIDS, HIV (Human Immuno-deficiency Virus) infection, or a condition associated with either?				
c. ever had a positive blood test for AIDS or HIV infections?				
d. ever had consultation, hospitalization or surgical operation due to any condition not mentioned above during the past five (5) years?				
e. any mental impairment, physical defect, tumor, lump, or abdominal growth in any part of the body?				
f. ever had during the past two (2) years				
(1). loss of weight ; dizzy spells; blood-spitting; abnormality in breathing, urination or bowel movement; or pain in any part of the body?				
(2). medical examinations, X-ray, ECG, blood test or other diagnostic tests?				
ANSWER IF FEMALE				
12. a. Has the person to be insured ever had an unsual bleeding or abnormality in menstruation, pregnancy or childbirth?				
b. To the best of your knowledge and belief are you now pregnant?				

13. What is your general state of health? (Explain below if answer is Fair or Poor)

Person to be insured: ☐ Excellent ☐ Fair ☐ Poor Payor: ☐ Excellent ☐ Fair ☐ Poor

14. Special instructions or Explanations (Give full details on all YES answer to Question 9 through 12. Show question number as reference. Furnish dates, names and address of doctors, hospitals, etc.)

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.

By applying for any Permanent Insurance Plan and supplying my personal data, 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.

✓ _____

Print Name & Signature

DECLARATION

I/We hereby declare that all the statements and answers to the Questions herein are complete, true and correct, as well as those that I/We may make to the Association's Medical Examiner in continuation of this application. I/We agree that the several answers, statements and agreements contained herein shall be considered part of my/our application for insurance. Finally, I/We agree as follows:

1. That this declaration, with the answer to be given by me/us to the Medical Examiner, shall be the basis of the policy and forms part of same.

2. That if the application is accepted and a policy issued in my/our favor, I/We bind myself/ourselves to accept the same.

(Continued on next page)

DECLARATION *(Continued)*

3. That if the application is declined or the policy applied for does not take effect as stated hereunder, whatever sum of money that I/We paid, will be returned to me/us, if living, otherwise, to the persons named as my beneficiary/ies appearing under item No. 7 of this application.

4. That the said policy shall not take effect until the first premium has been paid, and the policy has been delivered to and accepted by me/us in person while I am/we are in good health.

5. That in case of extraordinary inflation between the date of delivery of the policy and the date when the obligation of the Association hereunder becomes demandable, the decrease in value of the Philippine peso shall be borne by the owner or other persons to whom the proceeds of the policy may become payable, and in case of extraordinary deflation, the Association shall bear the loss occasioned by the increase in value of said currency.

6. That the agent or representative taking this application has no authority to make, modify or discharge contracts, or to waive any of the Association's right or requirements.

7. That if I/We accept delivery of the policy and retain the same without objection such retention will amount to an approval on my/our part of the insurance as written therein and constitute a ratification by me/us of any correction in addition to this application including extra premiums, liens or restrictions imposed by the Association in the space "Reserved for Association endorsements only"

I/We agree that photographic or duplicate copy of this application as corrected or added to by endorsement or otherwise and attached to the policy, issued in accordance with Section 50 of the Insurance Code, shall constitute sufficient notice to me/us of the changes made.

8. That the person who filled in the blank spaces in the application, regardless of his being the soliciting agent or any other person, acted under my direction, that I/We have read the same carefully, or in case applicant cannot read or understand the language that before my/our affixing, my/our thumbmark in this application, it has been read and translated to me/us, and

9. That I/We hereby warrant the eligibility of the beneficiary/ies named in this application and further warrant that I/We shall not in the future designate any beneficiary who is ineligible under Article No. 2012 and 738 of the Civil Code of the Philippines (Republic Act No. 386).

Should the Association pay the proceeds of the policy to an ineligible beneficiary, believing in good faith that said beneficiary is eligible, said payment shall free the Association from liability under the policy, if, within sixty (60) days from the presentation by the ineligible beneficiary or beneficiaries of the claim and proof of death of the insured, no adverse claim is filed with the Association by the person legally entitled to the proceeds of the policy.

10. In case the company is unable to comply with the relevant Customer Due Diligence (CDD) measures, as per under the Anti–Money Laundering Act (AMLA), as amended, and relevant issuance, due to the fault of the client, the company may apply the following:

a) Measures to restrict services available or prohibit any further transactions on the contract/policy until full and proper CDD measures had been successfully conducted; and

b) In case the foregoing is unsuccessful, terminate the business relationship. The exercise of the company of this measure shall only entitle the client/customer to receive the unused portion of the premiums or withdrawal value, if any, whichever is applicable.

11. Be bound by the obligation set out in the relevant UN Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

Signed at ✓_____ this ✓_____ day of ✓_____ 20 ✓_____

	✓_____ Signature of Person to be Insured	✓_____ If Insured is not the Payor Signature of the Payor	Right Thumbmark of Payor
Right Thumbmark of Insured	Witness: ✓_____ For MBAI Personnel / Sales Force Name & Signature of Insurance Representative	✓_____ Code No.	✓ *Right Thumbmark of Payor* If Insured is not the Payor

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AUTHORIZATION FOR SALARY DEDUCTION

Application No. _____ _____
Date

TO: FINANCE/DISBURSING/AGENT OFFICER

_____

_____

I hereby authorize the AFP/PNP/PCG/BFP/BJMP Finance/Disbursing Officer to deduct from my salary the amount of _____ _____ (P _____) every month for _____ months beginning _____ for the payment of my insurance premium and remit the same to **ARMED FORCES AND POLICE MUTUAL BENEFIT ASSOCIATION, INC. (AFPMBAI).** In the event that my present Net Take Home Pay (NTHP) is insufficient to cover the monthly premium, I also authorize my disbursing/Finance 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.

The 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.

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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.

_____
Print Name & Signature

WITNESSED BY:

_____
Rank SN BR of SVC

_____ _____ _____
(Name of Insurance Representative and Code No.) PhilSys. No. (PSN) Unit Assignment

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_____
Print Name & Signature

WITNESSED BY:

_____
Rank SN BR of SVC

_____ _____ _____
(Name of Insurance Representative and Code No.) PhilSys. No. (PSN) Unit Assignment