



Master Policy Number	Effective Date	Certificate Number
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**INDIVIDUAL APPLICATION FOR GROUP INSURANCE**

Last Name		First Name		Middle Name	
Date of Birth		Age	Place of Birth	Nationality	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Annulled <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated		TIN/SSS/GSIS	Height _____ kgs/lbs Weight _____ ms/ft. in.	
Residence Address			Telephone Number		
Employer/Association/Union			Mobile Number		
Occupation/Position		Basic Salary	Date Employed/Regularization	Source of Income	
Plan of Insurance		Date of Effectivity		Premium	
Amount of Insurance		Life	Riders		

**Beneficiaries**

Name	Date of Birth	Age	Relationship	% share in proceeds

**Eligible Dependents**

Name	Date of Birth	Age	Relationship

**HEALTH DECLARATION**

1. I have not now, never had, nor consulted any physician for: cerebral hemorrhage, heart disease, high blood pressure, tuberculosis, kidney disease, cancer tumor, diabetes, nor any disease, injury nor impairment not mentioned above; nor undergone any operation or hospitalization.  
 2. I have never been declined, accepted substandard, postponed nor offered a policy different from that applied for.  
 3. I possess sound health, am able to perform the normal activities in pursuit of my livelihood and am free from any physical or mental infirmity.  
 EXCEPTIONS: (State in full details)

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**DISCLOSURE:** in accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at [www.insurance.gov.ph](http://www.insurance.gov.ph).

I/We hereby agree that I/we have informed of all my/our citizenships, residencies and tax residencies, and provided with my/our taxpayer identification number(s). I/We agree to promptly update of any changes to said information. I/We authorize Etiqa Philippines to disclose my/our personal information to any government or tax authority (within or outside the Philippines) for the purposes of ensuring compliance with applicable laws and regulations. I/We agree that Etiqa Philippines shall have the right to: (a) require the claimant(s) and/or payee(s) of the Policy to provide with their above-mentioned personal information and/or sign such documents as may reasonably require; and (b) disclose said personal information to any government or tax authority (whether within or out of the Philippines) for the purposes of compliance with applicable laws and regulations. If I/we fail to any of the above-mentioned acts, I/we agree that Etiqa Philippines may provide my/our personal information to such government or taxation authorities to comply with the applicable laws and regulations.

I HEREBY DECLARE that all the foregoing answers and statements are complete and true and correct to the best of my knowledge and belief. I hereby agree that if there be any fraud and misrepresentation in the above statement material to the risk, the Insurance Company upon discovery with one (1) year from Effectivity Date of insurance shall have the right to declare such insurance null and void.

Witness	Date Signed	Signature of Employee/Member
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**For Home Office use only**

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