PhilPlans Think Ahead!

PHILPLANS FIRST INC.
12th Floor, STI Holdings Center,
6764 Ayala Avenue, 1226 Makati City

This form must be completely filled out by the Planholder in BLACK INK.

Nuestra Señora De Salvacion Funeral Parlor, Inc.
Funeral Parlor and Crematorium
Smart: 0919-300-1962; Globe: 0915-757-1962
FunerariaSalvacion.com; Nuestrasenora_funeral@yahoo.com

APPLICATION FORM

Vivir Package

I hereby apply to purchase from PHILPLANS a plan described herein in accordance to the Plan Data set forth in this application and I hereby certify that the data and other information stated herein are written by me or under my direction.

PERSONAL INFORMATION OF APPLICANT (Write "N/A" if not applicable.)

A. FIRST NAME

MIDDLE NAME

LAST NAME

B. GENDER ○ Male ○ Female

HONORIFIC ○ Mr. ○ Miss ○ Mrs. ○ Dr. ○ Atty. ○ Engr.

C. CIVIL STATUS ○ Single ○ Married ○ Widowed ○ Separated

D. CITIZENSHIP (If Non-Filipino, please specify)
Planholder | Spouse

E. DATE OF BIRTH (Month/Day/Year) / / PLACE OF BIRTH

F. MOTHER'S MAIDEN NAME

G. MONTHLY HOUSEHOLD INCOME
○ Less than P10,000 ○ P30,001-P50,000 ○ P100,001-P300,000
○ P10,001-P30,000 ○ P50,001-P100,000 ○ P300,001-P500,000
○ More than P500,000

H. SOURCE OF INCOME

I. IDENTIFICATION (With Picture) ○ UMID / SSS ○ Passport ○ Company ○ PRC ○ Driver's License

J. OCCUPATION (Exact Duties/Position)

K. NAME OF COMPANY

☐ Employed

○ Government (national/local gov't office/AFP/PNP) ○ Hotel/Restaurant/Food ○ Agriculture/Forestry ○ Computer/Internet/Information Technology
○ Engineering/Construction/Real Estate ○ Insurance (life/non-life) ○ Banking/Lending/Financial Services ○ Consumer Retail/Pharmaceutical/Automobile Sales
○ Arts/Media/Advertising/Communications ○ Telecommunications ○ Education/Learning/Consulting ○ Personal Services (salon, barbershop, massage, etc.)
○ Logistics/Cargo forwarding/Remittance ○ Healthcare/Medical ○ Manufacturing ○ All Other Services (e.g. security/janitorial/messengerial)

☐ Professional (doctor, lawyer, engineer, architect, CPA, teacher) ☐ Self-Employed ☐ Stay-at-home spouse/Housewife ☐ Not employed/Student
☐ Farmer/Fisherman/Other farming-related ☐ OFW ☐ Retired/Pensioner ☐ Other sources

L. CONTACT DETAILS
Landline No.
Office Telephone No.
Cellphone No.
E-mail Address
Preferred Mode of Contact

M. PERMANENT/RESIDENCE ADDRESS (No., St., Dist., City, Province, Country, Zip Code)

N. OFFICE/BUSINESS ADDRESS (No., St., Dist., City, Province, Country, Zip Code)

PREFERRED BILLING/MAILING ADDRESS ○ Permanent Res. Address ○ Office Address

Beneficiaries (If named beneficiary is below 18 years old, please indicate guardian)

A. Primary (Last Name, First Name, Middle Initial) | B. Date of Birth (Month/Day/Year) | C. Relationship to Applicant

Secondary (Last Name, First Name, Middle Initial) | Date of Birth (Month/Day/Year) | Relationship to Applicant

Guardian (Last Name, First Name, Middle Initial) | Date of Birth (Month/Day/Year) | Relationship to Applicant

A. Nominee - if applicable (Last Name, First Name, Middle Initial) | B. Date of Birth (Month/Day/Year) | C. Relationship to Applicant

A. No. of Dependents / Children

B. Education Level Attained
○ Elementary ○ College
○ High School ○ Postgraduate

C. Financial Products Owned (check all applicable)
○ Bank products (savings/checking/personal loan) ○ Pre-need Plan ○ Credit Card
○ Investment products (stock/mutual funds) ○ Life Insurance Plan ○ Health Card (HMO)

D. Car owner? ○ YES ○ NO

E. Residence owned? ○ YES ○ NO

PLAN DATA

A. PLAN NAME

ANNUAL INSTALLMENT | PAYING PERIOD

CONTRACT PRICE | MATURITY PERIOD

EDUCATION TYPE (IF APPLICABLE)
○ 5-Year College ○ Elementary
○ 4-Year College ○ High School
○ 2-Year College

MATURITY BENEFIT /INITIAL EDUCATION BENEFIT / TOTAL EDUCATION BENEFIT / INITIAL MEMORIAL SERVICE BENEFIT

B. METHOD OF PAYMENT
○ Cash ○ Check ○ Credit Card

C. PAYMENT MODE
○ Annual ○ Quarterly ○ Spot Cash
○ Semi-Annual ○ Monthly

D. INSURANCE BENEFIT
○ With Insurance ○ Without Insurance

E. TOTAL AMOUNT PAYABLE
MODAL INSTALLMENT
PLAN VAT
PLAN FEE (VAT Inclusive)
TOTAL AMOUNT PAYABLE

A. Any Existing Plans with PhilPlans? ○ YES ○ NO

If yes, do you want to update the contact information in all your other plans with us (using the data on this form)?

○ Yes, I want to update the contact information in all my other plans.

○ Yes, except for the following plans:

PLAN NUMBER	REASON

B. Purpose for Buying this Plan (check all applicable)

○ For my child/ren's education ○ For business capital
○ For my family's protection ○ For investment
○ For my pension/retirement

C. How did you learn about PhilPlans? (check all applicable)

○ PhilPlans agent ○ Family/Relatives/Friends ○ Internet website
○ TV ads ○ Social media (Facebook, Youtube, etc.) ○ Newspaper/Magazine ads
○ Radio ads ○ Outdoor/Billboards/Bus ads ○ Brochures/Flyers

DECLARATION AND REPRESENTATIONS

PRESENT HEIGHT		PRESENT WEIGHT	
	○ ft ○ cm		○ lbs ○ kgs

DETAILS TO YES ANSWERS

Include date, diagnosis, durations of illness, result of treament or tests done and names/addresses of attending physicians and medical facilities.

Yes	No	
○	○	During the past years has the Applicant consulted any physician for medical treatment, had any laboratory or other diagnostic tests or sought medical advice for treatment or been confined in a hospital, clinic or similar institutions?
○	○	Has the Applicant ever taken habit-forming drugs, alcoholic drinks or smoked cigarettes? (If YES, please specify and indicate amount/portions, frequency and duration/length of time.)
○	○	Does the Applicant have any abnormality or impairment in his health or physical condition?
○	○	Has the Applicant ever engaged in motor sports, parachuting, underwater diving?

All statements in this application shall form part of the contract between PhilPlans (the Company) and myself.

I am within acceptable age for sustained insurability as specified in the Plan Contract.

I hereby authorize any entity or person to give the Company all information regarding my health and medical history solely for the purpose of assessing my fitness for insurance coverage. The Company shall maintain the strictest confidentiality in processing the same. A photographic copy of this authorization shall be valid as the original.

No coverage shall take effect without the written approval by the Company of my application.

I shall immediately notify the Company in writing of any change in: (a) my residence, office and/or mailing address; (b) my contact phone numbers and/or email address; and (c) my civil status or my designated beneficiaries.

I agree that any notice from the Company provided to me through these channels shall be considered as official notice for enforcement of the Plan Contract and compliance with applicable law, shall be effective and binding on me, and shall be conclusively deemed to be sufficient receipt by me of such notices. However, any error or discrepancy between the information transmitted via these channels and the official records of PhilPlans shall not in any way prejudice or give rise to any liability on the part of the Company.

I am solely responsible for maintaining the confidentiality, security and integrity of access to the email address and the cell phone number that I have provided. The Company shall take reasonable security precautions for communicating through these channels, but shall not be liable for any interception which may occur beyond the reasonable control of the Company.

I hereby consent, without need of prior notification, to the processing, storage and disclosure by the Company of all such personal and/or sensitive personal information in this form for the enforcement of my plan contract, and for all purposes deemed fit by the Company, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk management, underwriting and administration of insurance coverage and claims, data analytics and data sharing with the Company. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured.

I agree that the Company may store said data for the duration of the contract and a reasonable time thereafter.

Lastly, I agree that in the event that I am not eligible for insurance coverage, the Plan Contract may continue with No Insurance Benefit (NIB).

Dated this _____ day of _____ year _____ at _____, Philippines

I HEREBY CERTIFY THAT I HAVE FULLY READ AND UNDERSTOOD THE BENEFITS AND FEATURES OF THIS PLAN AND AGREE TO BE BOUND BY THE PROVISIONS OF THE PLAN CONTRACT.

✓ _____

Signature of Applicant over Printed Name

Applicant's Right Thumb Mark

SPECIMEN SIGNATURES OF APPLICANT

1. ✓ _____ 2. ✓ _____

I/We certify that I/we personally saw the Applicant, and can attest to her/his legal identity and he/she personally signed this application form. *(Indicate "N/A" on blank spaces)*

Signature of Sales Counselor	Name of Sales Counselor (PRINT NAME)	Code	Production Crediting (%)	Cellphone No.

	PRE-SCREENER 1		PRE-SCREENER 2	
PRE-SCREENED BY		/ /		/ /
	Signature Over Printed Name	**Date (Month/Day/Year)**	**Signature Over Printed Name**	**Date (Month/Day/Year)**