PhilCare
Make Health Happen

APPLICATION FOR HEALTH 360, HEALTHPRO AND HEALTHLUXE PROGRAMS

Application No.

Agreement No.

☐ **NEW BUSINESS** ☐ **RE-APPLICATION** ☐ **GROUP TO INDIVIDUAL**

PART I

LAST NAME	FIRST NAME	MI

PERMANENT ADDRESS — ZIP CODE

RESIDENCE TEL NO

OFFICE ADDRESS — BUSINESS TEL. NO

MOBILE NO.

OCCUPATION / JOB TITLE	NATURE OF BUSINESS	TIN	EMAIL

BIRTHDATE (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP: ☐ FILIPINO ☐ OTHERS: _____	SEX	NO. OF CHILDREN: (SINGLE AND BELOW 21 YEARS OF AGE)

AGE	HEIGHT	WEIGHT	CIVIL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED	ESTIMATED TOTAL MONTHLY INCOME ☐ 10,000 or below ☐ 10,001 - 20,000 ☐ 20,001 - 50,000 ☐ 50,001 - 100,000 ☐ 100,001 and up

PART II TYPE OF PROGRAM

CHOOSE ONE PLAN

HEALTH360	**HEALTHPRO**	**HEALTHLUXE**
☐ **PLAN 100** ☐ **PLAN 300**	☐ **PLAN 150**	☐ **PLAN 150**
☐ **PLAN 150** ☐ **PLAN 500**	☐ **PLAN 300**	☐ **PLAN 300**

MODE OF PAYMENT

☐ ANNUAL ☐ SEMI-ANNUAL ☐ QUARTERLY

**MONTHLY MODE OF PAYMEN IS ALLOWED ONLY FOR FAMILY PROGRAMS WITH MINIMUM OF FIVE (5) MEMBERS.*

ADDITIONAL BENEFIT DESIRED ☐ **PHILHEALTH RIDER**

DENTAL

☐ PACKAGE 1 ☐ PACKAGE 2 ☐ PACKAGE 3

FORM OF PAYMENT

☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ OVER THE COUNTER ☐ AUTO DEBIT ARRANGEMENT

CARD NAME _____

CARD NUMBER _____

PART III ☐ **CHECK THIS BOX IF YOU ARE APPLYING ONLY FOR YOUR SPOUSE AND/OR CHILDREN (with principal as Payor)**

FAMILY MEMBERS APPLYING FOR MEMBERSHIP	DOB	AGE	SEX	HT	WT	RELATIONSHIP TO PRINCIPAL / PAYOR	OCCUPATION	CITIZENSHIP

IF YOU ARE NOT ENROLLING ALL YOUR CHILDREN WHO ARE SINGLE AND BELOW 21 YEARS OF AGE, PLEASE STATE REASON(S) WHY ON A SEPARATE SHEET OF PAPER.

By signing below, I certify that information given by me is true and correct and that any material misrepresentation or falsity therein shall be construed as act to defraud PhilHealth Care Inc. (PhilCare), and a sufficient ground for legal action and the rejection of my application and membership. I hereby authorize PhilCare to inquire about and investigate all declared information from whatever sources PhilCare may consider appropriate.

I agree that receipt of the corresponding membership fees by PhilCare does not constitute acceptance of my application until the corresponding application has been approved and my PhilCare membership card has been issued to me. Effectivity of the cards startrs 7 days from notice of the acceptance of my application. Any incident, illness or condition that occurs prior to Effectivity Date will not be covered.

Approval of this application is subject to the receipt of full payment, application for, photocopy of valid ID with signature. Further, I agree that the application form and related documents submitted to PhilCare will not be returned to me for whatever reason. In case of disapproval of my application, . the membership paid and remitted will be refunded to me by PhilCare. PhilCare is under no obligation to provide me with the reason for disapproval of my application.

I have read and understood completely the Terms and Conditions governing the issuance and use of the health card that I choose.
I also reconfirm my agreement to the Declaration stated above

_____ _____

Signature over Printed Name of Principal Applicant DATE:

TO BE FILLED UP BY THE SERVICING AGENT:

PHILCARE **Application No.**

RE: LETTER OF RE-AFFIRMATION

Please be informed that I have explained well to my client the contents of the application and the limitations of his/her coverage.
I hereby certify that the data and other information stated herein are written by my client or by me under his/her supervision.

_____ / _____

Signature over Printed Name of Servicing Agent / Signature over Printed Name of Servicing Agent

AGENCY	UNIT	PERSONAL		AGENCY	UNIT	PERSONAL
			/			

AGENT'S CODE **AGENT'S CODE**

DATE: _____ / DATE: _____

HOW DO YOU WANT THE AGREEMENT AND MEMBERSHIP PACKAGE TO BE SENT?

☐ TO BE PICKED UP BY AGENT ☐ TO BE PICKED-UP BY MEMBER ☐ TO BE DELIVERED AT MEMBER'S ☐ PERMANENT ADDRESS ☐ OFFICE ADDRESS

HOW DO YOU WANT YOUR SUCCEEDING BILLING TO BE SENT?

☐ MAILED TO PERMANENT ADDRESS ☐ MAILED TO OFFICE ADDRESS

FOR PHILCARE USE ONLY

MEMBERSHIP WORKSHEET

COMPUTATIONS

CERTIFICATE #	ENROLLEE'S NAME	ISSUE AGE	MEMBERSHIP FEE	DENTAL FEE	TOTAL

REMARKS:	TOTAL	
	GRAND TOTAL	

PAYMENT OR #	AMOUNT:	DATE:	BY:

UNDERWRITING ACTIONS

☐ APPROVED ☐ CANCELLED ☐ DISAPPROVED ☐ RECONSIDERED ☐ ADDITIONAL REQTS.

DATE:	SIGNATURE:

NAME	REASONS

☐EXCLUSIONS	CODE

EFFECTIVE DATE:	EXPIRATION DATE:
ENCODED BY/ DATE:	VERIFIED BY/ DATE:

DATE	REQUIREMENTS/RECOMMENDATIONS/ACTIONS	NAME/SIGNATURE

MEDICAL QUESTIONNAIRE : Answer all the following questions in the appropriate check box provided below. If you are applying for a family coverage, all questions are applicable to each applicant. Use the space provided below to give full details of items with "YES" answers.*

	Check Box YES	Check Box NO
1. Have you ever had a history of, and/or treatment, consultation or known indication for:		
a. Disorder of eyes, nose, or throat ?	☐	☐
b. Dizziness, fainting, convulsion, headache, speech defect, paralysis or stroke, mental or nervous disorder ?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood-spitting, tuberculosis, asthma or other chronic respiratory disorders ?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels ?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder ?	☐	☐
f. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs ?	☐	☐
g. Diabetes, thyroid or other endocrine disorder ?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones, such as spine, back or joints ?	☐	☐
i. Deformity, lameness or amputation ?	☐	☐
j. Disorder of skin, lymph glands, cysts, tumor or cancer ?	☐	☐
k. Allergies, anemia, or other disorder of the blood ?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit forming drugs ?	☐	☐
2. Are you now under observation or taking treatment ?	☐	☐
3. Have you had any change in weight in the past years ?	☐	☐
4. Other than the above, have you:		
a. Had any physical disorder or any known indication thereof ?	☐	☐
b. Had a medical examination, consultation, illness, injury, or surgery ?	☐	☐
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility ?	☐	☐
d. Had electrocardiogram, x-ray, or other diagnostic tests ?	☐	☐
e. Been advised to have any diagnostic test, hospitalization or surgery which was not completed ?	☐	☐
5. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition ?	☐	☐
6. Have you ever applied for or received a pension payment, or benefit due to injury, sickness or disability ?	☐	☐
7. Have you a parent, brother or sister who died of or had high blood pressure, tuberculosis, diabetes, cancer, heart or kidney disease, or mental illness ? If so, at what age ?	☐	☐
8. Do you or other members of the family smoke ?	☐	☐
a. If yes, since when ? How many sticks a day ?_____		
b. If you have quit smoking, since when ? How long have you smoked ? How many sticks a day ? _____		
9. FOR FEMALES ONLY		
a. Have you ever had any abnormal menstruation, pregnancy, childbirth, or disorder of the female organ or breasts ?	☐	☐
b. Are you now pregnant ? If yes, how many months ? _____	☐	☐

** Use the space provided below to give full details of items with "YES" answers.*

NAME OF FAMILY MEMBER	DATE OF HISTORY TREATMENT, CONFINEMENT, ETC	CHIEF COMPLAINTS AND DIAGNOSIS	TREATMENT AND RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL

(Kindly continue on the appropriate space on the reverse side of this form, if necessary)

We hereby declare and agree that all statements and answers contained herein and in any addendum annexed to this application are full, complete and true and binds all parties in interest under the Health Care Coverage (the Agreement) herein applied for, that there shall be no contract of health care coverage unless and until an Agreement is issued on this application and the full Membership Fee according to the mode of payment is paid during the good health of proposed Member(s); that the health care coverage of any Member shalltake effect only on the Effective Date as indicated in the issued Agreement or the actual date full Membership Fee was paid, whichever is later; that no information acquired by any Representative of PhilCare shall be binding upon PhilCare unless set out in writing in this application; that any physician is, by these presents, expressly authorized to disclose or give testimony at anytime relative to any information acquired by him in his professional capacity upon any question affecting the elegibility for health care coverage of the proposed Members and that the acceptance of any Agreement issued on this application shall be a ratification of any information on correction in addition to this application.

We hereby affirm that we have read and understood the contents of the health care contract as discussed in the attached Re-affirmation Letter. As proof of the foregoing, we are submitting a signed conforme of the same with this Application Form.

We hereby understand that we, the enrollees, will only start availing of the benefits of the program upon the effectivity of the policy.

SIGNED AT _____ THIS _____ DAY OF _____

_____ PRINTED NAME AND SIGNATURE OF WITNESS

_____ PRINTED NAME AND SIGNATURE OF PRINCIPAL APPLICANT

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

(The form below should be completed for each case)

I hereby authorize any person, organization, or entity that has any record or knowledge of my health and/or that of _____ to give to the PhilhealthCare, Inc. any and all information relative to any hospitalization, consultation, treatment, or any other medical advice or examination. This authorization is in connection with the application for health care coverage or with any benefit availed and with any claim for benefits under such coverage. A photographic copy of this authorization shall be as valid as the original.

_____ PRINTED NAME AND SIGNATURE OF WITNESS

_____ PRINTED NAME AND SIGNATURE OF PRINCIPAL APPLICANT

_____ **PRINTED NAME AND SIGNATURE OF AGENT AND CODE NO.**

_____ **APPLICATION NO.**

NAME OF FAMILY MEMBER	DATE OF HISTORY TREATMENT, CONFINEMENT, ETC	CHIEF COMPLAINTS AND DIAGNOSIS	TREATMENT AND RESULTS	NAME AND ADDRESS OF PHYSICIAN AND HOSPITAL