 APPLICATION FOR CORPORATE MEMBERSHIP

**Insular Health Care, Inc.**

2/F Insular Health Care Building, 167 Dela Rosa corner Legazpi Streets,

Legazpi Village, Makati City 1229 Metro Manila, Philippines

Tel: (632) 813-0131 Fax: (632) 813-7856

Email: support@insularhealthcare.com.ph

Website: http://www.insularhealthcare.com.ph

**PLEASE WRITE LEGIBLY IN BLOCK LETTERS. FILL OUT ALL BLANKS / BOXES WHERE APPLICABLE AND SUBMIT APPLICATION TO INSULAR HEALTH CARE AS SOON AS POSSIBLE. ONLY COMPLETELY FILLED-OUT APPLICATION WITH COMPLETE REQUIREMENTS, IF ANY, WILL BE PROCESSED.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LAST NAME | | | | | | | FIRST NAME | | | | | | | | | | | MIDDLE NAME | | | SEX |
| AGE | DATE OF BIRTH (mm/dd/yy) | | | | PLACE OF BIRTH | | | | | | | | CIVIL STATUS | | MOBILE NUMBER | | | | RESIDENCE TELEPHONE NO. | | |
| PERMANENT ADDRESS  | | | NO. & STREET | | | | | TOWN/BARANGAY | | | | | | | | | CITY/MUNICIPALITY | | | ZIP CODE | |
| COMPANY NAME | | | | | | | | | DATE HIRED | | | | | OFFICE TELEPHONE NO. | | | | E-MAIL ADDRESS | | | |
| DEPARTMENT | | | | POSITION | | | | | | RANK  EXECUTIVE  MANAGER  SUPERVISOR  RANK & FILE | | | | | | | | | | | |
| PREFERRED HOSPITAL *(please state only one)* | | | | | | | | | | | | PREFERRED DENTAL CLINIC *(please state only one)* | | | | | | | | | |
| **PLAN** | |  SUITE | | | | PRIVATE | | | | |  SEMI-PRIVATE | | | | |  WARD  PLAN TYPE: \_\_\_\_\_\_\_\_ | | | | | |
| **OPTIONAL**  **BENEFITS** | | DENTAL | | | | MATERNITY | | | | |  LIFE INSURANCE | | | | | PRESCRIPTION MEDICINE | | | | | |

FOR DEPENDENT’S COVERAGE *(following hierarchy guidelines)*

* *Single employees* : Principal should enrollParent/s first who is/are less than 65 years old and not gainfully employed; followed by the eldest sibling down to the youngest, who is/are 15 days to less than 21 years old, unmarried and not gainfully employed.
* *Single Parent employees* : Principal should enroll the eldest child down to the youngest, 15 days to less than 21 years old, unmarried and not gainfully employed.
* *Married employees* : Principal should enroll their spouse first who is less than 65 years old, followed by the eldest child down to the youngest, 15 days to less than 21 years old, unmarried and not gainfully employed.

Note: If they are currently covered by another HMO, kindly furnish us immediately a photocopy of their current membership card with the date of expiration.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME OF DEPENDENTS | **Date of Birth** | **Age** | Relationship | Occupation | **Plan** | **Preferred Hospital** | **Preferred Dental** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |

FOR LIFE (GROUP TERM)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| NAME OF BENEFICIARIES \* | **Date of Birth** | **Age** | Relationship | NAME OF BENEFICIARIES \* | Date of Birth | Age | Relationship |
| 1 |  |  |  | 3 |  |  |  |
| 2 |  |  |  | 4 |  |  |  |

\*The following are recommended beneficiaries: spouse, son/daughter, parent, brother/sister

**Printed Name & Signature of Dependents (if any)**

|  |  |  |  |
| --- | --- | --- | --- |
| Please indicate details of all known illnesses / injuries. Health conditions covered are only those declared in the application provided these are not part of the permanent exclusions to the program or illnesses / injuries excluded in the underwriting process of your application. Genuinely unknown (and therefore undeclared) health conditions will be evaluated for possible consideration provided these are not concealment cases. For additional information, use back page. Any information contained herein is final. | | | |
| **Name of Principal and Dependents** | **Chief Complaints**  **And Diagnosis** | Date, Duration **Treatment and Results** | **Name and Address of** Physician and Hospital |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| I hereby declare that all statements and answers herein are full, complete and true.  *Printed Name & Signature of Applicant Date Signed*    **AUTHORIZATION TO FURNISH MEDICAL INFORMATION AND TO PROVIDE PERSONAL AND**  **SENSITIVE PERSONAL INFORMATION TO AUTHORIZED PERSONNEL**  I hereby authorize any person, organization or entity that has any record or knowledge of my health and/or that of my qualified dependents (if any) to give to the Insular Health Care, Inc. any and all information concerning my hospitalization, consultation, or treatment.  I also authorize Insular Health Care, Inc. to access and process my personal and sensitive personal information (and/or that of my dependents) and provide said information to any of the authorized representative/s of my employer.  This authorization is in connection with the application for health care coverage with Insular Health Care. Inc. and for other purposes such as, but not limited to, my employer’s need to evaluate my medical condition in determining my health coverage. This authorization shall continue to be valid unless revoked in writing. A photographic copy of this authorization shall be as valid as the original.    *Signature of Applicant Date Signed Printed Name & Signature of Agent/Witness*   |  |  |  | | --- | --- | --- | | 1 | 3 | 5 | | 2 | 4 | 6 | | | | |