227 JP Rizal St., Project 4, Quezon City
Tel. No. (632) 8962-3408

INDIVIDUAL APPLICATION FORM

Group Micro Life Insurance Plan

Cooperative: _____Product: ( )BLIP ( )CLIP **/ Membership:** ( )New ( ) Renewal

Applicant	Last Name	First Name		Middle Name			
Address							
Nationality		**Civil Status**		**Gender**		**Tel. No.**	
Place of Birth				**Birth Date**			
Occupation *(state duties)*							
Source of Income		**TIN**					
GSIS / SSS / Drivers' License / Other ID No.							
Name of Beneficiary (ies)		**Age**	**Relationship to Applicant**				
Note: If there are two (2) or more beneficiaries, proceeds shall be divided equally.							

___ **TPD COVERAGE: please check the coverage to be availed: __ TPD10 __TPD30 __TPD50 __TPD80 __TPD100**

___ **HIB COVERAGE: please check the coverage to be availed: __ HIB300 __HIB500**

I hereby declare that I am/we are in good health and entirely free from any physical or mental impairment and that during the last five (5) years, I/we have not consulted or been treated or examined by a doctor for any disease or injury for more than two (2) weeks or been confined to a hospital for any length of time or had surgical operation before.

Thumbmark if unable to sign

I hereby allow NATCCO Mutual Benefit Association, Inc. (NATCCO MBAI) to utilize the information I supplied in this application as basis for any subsequent application for insurance coverage. I signify my consent and agree that NATCCO MBAI: (a) may collect, use and disclose my personal data as provided in this document or obtained by NATCCO MBAI as a result of being its member, for the purpose of processing this document and (b) may disclose and share the said information to its subsidiaries and/or affiliates, reinsurer or regulatory authorities. It should be understood that I have a right to revise the information that I have provided including the deletion of the given information in accordance with the Data Privacy Act of 2012 and the data protection policy of NATCCO MBAI.

Dependent/s to be insured:

	NAME	**Relationship to Applicant** (spouse/parent/ child/sibling)	**Birth Date**	**Age**
Adult				
Minor				
Minor				
Minor				

_____ _____

Signature of Applicant **Date**

CREDIT LIFE INSURANCE PLAN (CLIP)

LOAN DETAILS:

Loan amount: _____ Loan period: (no. of months) _____ Loan coverage (start & end date): _____

I hereby certify that the above information are all true and correct based on my knowledge. Moreover, I hereby accept the policies and guidelines of the NATCCO MBAI.

For Branch Staff only

Share Capital		**BLIP (Damayan) Contribution Amount**	
Deposits		**BLIP (Damayan) Period of Coverage**	
Amount of Loan		O.R. / G.V. No.	
Term of Loan		**Coop Code**	

Prepared by: _____
Printed name over signature / designation

Approved by: _____
Printed name over signature / designation

NATCCO MBAI HEALTH QUESTIONNAIRE

Cooperative Name: _____

Last Name	First Name	Middle Name	Member-Borrower ☐ Dependent ☐	Date of Birth mm/dd/yyyy	Age	Height	Weight

Please answer the following questions by checking the "Yes" or "No" box.

	YES	NO	Use this space or the reverse hereof to give full details, for item(s) with "Yes" answer. Indicate the date, symptoms, diagnosis, duration, treatment result, name of attending physician, name and address of hospital/clinic. All statements contained herein and all attachments hereto are hereby made part of this form.
A. Have you ever had medical consultation or treatment pertaining to:			
1. Brain or nervous system			
2. Lung or respiratory system			
3. Kidney or urinary system			
4. Heart or blood vessel			
5. Stomach or other abdominal organs			
6. Reproductive organs or breast			
7. Diabetes, cancer, tumor or blood diseases			
8. AIDS, HIV (Human Immuno-defficiency Virus) infection or a condition associated with either			
B. Have you ever had a positive blood test for AIDS or HIV infection?			
C. Have you ever had consultation, hospitalization or surgical operation due to any condition not mentioned above during the past 5 years?			
D. Have you had any mental impairment, physical defect, tumor or lump or abnormal growth in any part of your body?			
E. Have you ever had any major organ transplant?			
F. Have you ever had during the past 2 years: 1. Loss of weight; dizzy spells; blood spitting; abnormality in breathing, urination or bowel movement; or unusual pain in any part of the body 2. Medical examinations, X-ray, ECG, blood test or other diagnostic tests?			

I hereby certify that the above declarations are the most appropriate responses pertaining to my personal well-being. I understand that false information may be ground for contestability of insurance coverage. I further understand that the contestability period is within 6 months, from the effectivity of my insurance policy.

_____	_____	_____
Date Signed	Signature of Member-Borrower/Dependent	Branch Manager

AUTHORITY TO CARRY PROXY VOTES

I,_____, of _____ having been enrolled and
(NAME OF MEMBER) (NAME OF PRIMARY COOP)

accepted as NATCCO MBA, Inc. member, do hereby authorize my primary cooperative to send delegates to carry their proxy votes to NATCCO MBA, Inc. including my proxy vote(s).

_____	_____
Date signed	Signature over printed name