PUBLIC SAFETY MUTUAL BENEFIT FUND, INC
No. 318-320, Santolan Rd., Cor 1st and 2nd West Streets, San Juan, Metro Manila
Tel No 726-1675; 726-8070 TeleFax 726-7250; 725-4725
E-Mail customercare@psmbfi.com.ph

MEMBERSHIP APPLICATION FORM

Office Copy

Please print or type all information on the spaces provided.

Date Received

Last Name | **First Name** | **Middle Name** | **Qualifier** | **Sex** [ ] Male [ ] Female

Civil Status [ ] Single [ ] Widow/er [ ] Married [ ] Separated | **Height (ft)** | **Weight (lbs)** | **Date of Birth (MM/DD/YY)** | **Age** | **Distinguishing Marks**

Home Address _____

Place of Birth _____

Religion _____

GSIS/SSS No. _____

Pag-ibig No. _____

e-Mail Address | **Cell Phone No.**

Public Safety Agency [ ] Philippine National Police [ ] Bureau of Jail Management and Penology [ ] Bureau of Fire Protection [ ] Others *(Pls Specify)* _____ | **Account Number**

Rank | **Present Assignment (Unit / Address)** _____ | **Office Phone No.**

Date Entered Service (MM/DD/YY) | [ ] **Uniformed Personnel** [ ] **Non-Uniformed Personnel**

For Non-Uniformed Personnel / Civilian *(Pls check one option)*

Contribution	Sum Assured	Contribution	Sum Assured	Contribution	Sum Assured	Contribution	Sum Assured
[ ] P 50	P 26,923.07	[ ] P 300	P 161,538.46	[ ] P 600	P 323,076.92	[ ] P 900	P 484,615.38
[ ] P 100	P 53,846.15	[ ] P 400	P 215,384.62	[ ] P 700	P 376,923.08	[ ] P 1,000	P 538,461.53
[ ] P 200	P 107,692.31	[ ] P 500	P 269,230.77	[ ] P 800	P 430,769.23		

Designated Beneficiaries

Name (First, Middle, Last, Qualifier)	Relationship to the Insured Member	Birth Date	Percent Share (Total must be 100%, if not, will be distributed equally)	Remarks	Special Group Term Insurance (SGTI)	Basic Group Term (BGTP)	Burial Assistance Benefit (BAB)

(Pls. check if he/she is a beneficiary of the plans you enrolled in:)

All beneficiary designations are deemed revocable unless indicated otherwise. (Please use the back portion for additional beneficiaries.)

Health Statements:

	YES	NO
a. Have you ever been treated for or been advised by a licensed physician that you have any of the following diseases: Heart, Lung, Nervous, or Kidney Disorder, Hypertension, Diabetes, Cancer or any malignant tumor?		
b. Do you have any medical condition not stated above? Please specify: _____		
c. Have you been hospitalized, or have been treated by a physician for any reason during the last five (5) years?		
d. Are you in good health and free from any physical impairment, deformity or disease?		

Important: Non-disclosure of true information may lead to denial of claims.

Certification / Authorization

I hereby declare that all statements and answers contained herein are true, complete and correct to the best of my knowledge and belief, and shall form part of my application for Insurance. It is understood and agreed that this Insurance coverage shall take effect on the first day of the month for which the payroll deduction is made, if the payment of contribution is made thru Automatic Salary Deduction or the actual date of payment of first contribution, if directly paid to PSMBFI.

I further authorize PSMBFI to secure from any government office such as the Philippine National Police (PNP) and the National Statistics Office (NSO), any or all information and documents relating to my membership, such as but not limited to Birth Certificate (member and beneficiaries), Marriage Contract (member and beneficiaries), Service Records (member) and Advisory on Marriage (member and spouse).

_____ Member's Signature

_____ Date

Designated Beneficiaries

Name (First, Middle, Last, Qualifier)	Relationship to the Insured Member	Birth Date	Percent Share **(Total must be 100%, if not, will be distributed equally)**	Remarks	Special Group Term Insurance **(SGTI)**	Basic Group Term Plan **(BGTP)**	Burial Assistance Benefit **(BAB)**

(Pls. check if he/she is a beneficiary of the plans you enrolled in:)

PUBLIC SAFETY MUTUAL BENEFIT FUND, INC.

No. 318-320 Santolan Rd., cor 1st and 2nd West Crame
Brgy. West Crame San Juan City, Metro Manila

AUTHORITY TO DEDUCT

MEP, BGTP & BAB

(Kindly fill out all information & print legibly)

PSMBFI MEMBERS EQUITY PLAN (MEP)

For Uniformed Personnel

TO : CO, FINANCE OFFICE

SIR :

Please deduct 3% of my basic pay representing **PSMBFI Members Equity Plan** effective _____ and remit the same to Public Safety Mutual Benefit Fund, Inc.

SIGNATURE :_____ ACCOUNT NO.:_____ DATE: _____

RANK & NAME :_____ UNIT ASSIGNMENT:_____

I hereby undertake to deduct the amount indicated in the foregoing authorization and remit the same to PSMBFI.
Any change or stoppage of payment shall be effected only upon written request from PSMBFI.

_____
SIGNATURE OVER PRINTED NAME
DISBURSING OFFICER

SIR :

Please deduct an amount equivalent to my rank representing **PSMBFI Basic Group Term Plan** effective _____ and remit the same to Public Safety Mutual Benefit Fund, Inc.

SIGNATURE :_____

RANK & NAME :_____

RANK	BGTP AMOUNT
PO1 to PO3	25.00
SPO1 to SPO4	30.00

RANK	BGTP AMOUNT
Cadet, INSP to CINSP	50.00
SUPT to Dir Gen	60.00

I hereby undertake to deduct the amount indicated in the foregoing authorization and remit the same to PSMBFI.
Any change or stoppage of payment shall be effected only upon written request from PSMBFI.

_____
SIGNATURE OVER PRINTED NAME
DISBURSING OFFICER

SIR :

Please deduct an amount equivalent to the **OPTION** with a **CHECK** (✓) below, representing my contribution to the **PSMBFI Burial Assistance Benefit Plan**

SIGNATURE :_____

RANK & NAME :_____

✓	OPTION	COVERAGE
☐	32.00	42,000.00
☐	16.00	21,000.00

I hereby undertake to deduct the amount indicated in the foregoing authorization and remit the same to PSMBFI.
Any change or stoppage of payment shall be effected only upon written request from PSMBFI.

_____
SIGNATURE OVER PRINTED NAME
DISBURSING OFFICER