PUBLIC SAFETY MUTUAL BENEFIT FUND, INC
No. 318-320 Santolan Rd., Cor 1st and 2nd West Crame, Brgy. West Crame San Juan City
Tel. No. 725-4725; 726-8070 Telefax No. 726-7250
Email:psmbfi@info.com.ph TIN: 200-568486-000

APPLICATION NO.:_____

INSURANCE APPLICATION FOR ENDOWMENT AT AGE 56

PART 1. GENERAL INFORMATION - PLEASE USE BLACK INK, WRITE LEGIBLY IN BLOCK LETTERS AND CHECK THE APPROPRIATE BOX ☐ IS WHERE APPLICABLE

1. Proposed Insured	Surname	First Name		Middle Name
2. Date of Birth		Age:	Place of Birth:	
3. Gender & Civil Status	☐ Male ☐ Female	☐ Single ☐ Married	☐ Widow/er ☐ Separated/Annulled	Height: _____ Weight: _____
4. Residence Address: (No., Street, Brgy/Subd/ City/Town/Province/Zip Code)				Tel. No: _____ CP No:_____
5. Mailing Address: (No., Street, Brgy/Subd/ City/Town/Province/Zip Code)				
6. TIN/SSS/GSIS:		Source of Income:		
7. Unit Assignment:				Acct. No:

PART II. POLICY INFORMATION

8. Monthly Premium: Sum Assured:

9. Supplementary Benefits:
☐ WAIVER OF PREMIUM DISABILITY BENEFIT RIDER ☐ ACCIDENTAL DEATH BENEFIT RIDER

10. Premium Default Option:
☐ Net Surrender Value
☐ Premium Loan
☐ Reduced Paid-up Insurance
☐ Extended Term Insurance

NOTE: Reduced Paid-up Insurance is the default option in the absence of check mark in any box

11. Beneficiary/ies

Name	Date of Birth	Relationship to Proposed Insured
1		
2		
3		
4		
5		

Note: All beneficiaries are deemed revocable unless qualified in this form

12. MATURITY SETTLEMENT OPTION :

☐ **Option A** : Lump Sum equal to the Net Sum Assured

☐ **Option B** : 1. At maturity date, I wish to collect 20% of the Net Sum Assured/Maturity Value; and
2. Buy Paid-up Term Insurance up to age 75 with Sum Assured of:
☐ ₱10,000; or
☐ ₱ _____ (more than P10,000 but not to exceed the original Sum Assured)
3. Receive the remainder in equal monthly installment for 36 months

☐ **Option C** : 1. At maturity date, I wish to collect in lump sum an amount equal to the Net Sum Assured less the premium for the Paid-up Term Insurance up to age 75; and,
2. Buy Paid-up Term Insurance up to age 75 with Sum Assured of:
☐ ₱10,000 or
☐ ₱ _____ (more than P10,000 but not to exceed the original Sum Assured)

NOTE: Option B is the default option in the absence of check mark in any box

PART III: HEALTH DECLARATION (*If your answer is "YES" kindly provide details in a separate sheet of paper*)

	Proposed Insured Yes	Proposed Insured No
13. Are you in good health?	☐	☐
14. Have you ever had a positive blood test for the antibody to the aids virus HIV, HTLV III?	☐	☐
15. Do you smoke? If yes, please state daily consumption (stick/day) _____	☐	☐
16. Do you take alcoholic beverages? If yes, please state weekly intake.(bottle/brand)_____	☐	☐
17. Have you used narcotics, barbiturates, amphetamines, psychedelic drugs frequently or been treated for drug abuse?	☐	☐
18. Have you ever consulted a physician or practitioner or have been treated, confined in any infirmary, hospital or sanitarium, or had been informed that you have had:		
a. Asthma, Tuberculosis or any Respiratory Disorder	☐	☐
b. Blood Disease	☐	☐
c. Cancer, growth or other malignancies	☐	☐
d. Diabetes	☐	☐
e. Disease of the heart or circulatory system, hypertension, stroke	☐	☐
f. Kidney or Bladder Disorder	☐	☐
g. Liver Disease	☐	☐
h. Mental or Nervous Disorder	☐	☐
i. Stomach Disorder (peptic ulcer and other gastro intestinal disorders)	☐	☐
19. If Proposed Insured is **FEMALE** — A. Have you ever had any disorder of menstruation, pregnancy, reproductive organ or breast?	☐	☐
B. Are you presently pregnant? If yes, how many months? _____		
20. Are you engaged in hazardous hobbies like scuba diving, mountain climbing, car racing and skydiving?	☐	☐

AUTHORIZATION **APPLICATION No.**

I hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of me or my health, to give to PSMBFI any and all information about my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. I likewise give my consent to the conduct of personal investigation. A photocopy of this authorization shall be as valid as the original.

_____
Signature of PROPOSED INSURED over printed name

DECLARATION ON THE PROPOSED REPLACEMENT OF EXISTING POLICY (IES)

(Part I) FOR THE PROPOSED INSURED TO ANSWER

1) Total Life Insurance in Force on Proposed Insured:

Company	Basic Cover	Accident Rider/ Year of Issue
_____	_____	_____
_____	_____	_____
_____	_____	_____

2) Has there been or will there be any change in any existing insurance force? Yes ☐ No ☐

3). Will premiums for the insurance applied for be paid by a policy loan from any existing policy? Yes ☐ No ☐
If yes, please have the applicant complete a Replacement Notification Form

REMINDER: It is usually disadvantageous to replace existing life insurance Policy/ies with a new one, otherwise, you may

- Not be insurable on standard terms
- Have to pay a higher premium in view of higher age
- Lose financial benefits accumulated over the years
- Lose the benefit of incontestability of your old plan

(Part II) FOR THE AGENT TO ANSWER

1) Has there been or will there be any change in any existing insurance in force on the life of the proposed insured? ____Yes ____No
2) Will premiums for the insurance applied for be paid by Policy Loan from any existing policy? ____ Yes ____No
If Yes, have the applicant complete a Replacement Notification form.

GENERAL DECLARATION

I hereby declare that all the foregoing answers and statements and those stated in any required medical examinations or questionnaire, are complete, true and correctly recorded. I hereby agree that if there be any fraud or misrepresentation in the above statements material to the risk, PSMBFI upon discovery within one (1) year from the effective date of insurance shall have the right to declare such insurance null and void. I further agree that, the liabilities of PSMBFI under the insurance applied for shall begin and accrue on the Effective Date as defined in the Policy. I likewise give my consent to the conduct of personal investigation. This authorization is only in connection with my application for insurance and its resulting policy. A photocopy of this authorization shall be as valid as the original

SIGNED AT _____ this _____ day of _____, _____.

✔ _____
Customary Signature of Proposed Insured

WITNESSED BY:

_____ _____
Signature over printed name of Soliciting Agent Agent's Code Number

_____
Signature of Production Unit Manager

REPLACEMENT NOTIFICATION FORM

Proposed Insured_____ Date of Birth _____
Address _____

Existing Policies to be Replaced

Company Name (as it appears on the policy) _____
Insured's Name (as it appears on the policy) _____
Certificate No.: _____

I certify that I understand the nature of this change and hereby affix my signature below.

✔ Applicant's Signature _____ Date _____

Note: The replacing Insured should furnish a copy of this form to the issuer of the policy being replaced within seven (7) days from receipt of the application.

Pls. do not write below this line.

Revised: 05/16/12