FIRST GLOBAL PRO HEALTH CARE MANAGEMENT, INC.

Unit 1510 Cityland 10 Tower 11, H.V. dela Costa St., Salcedo Village Makati City
Telefax No. (02) 753-4971/ (02) 403-8387

A P P L I C A T I O N

I hereby apply to purchase from **FIRST GLOBAL PRO HEALTH CARE MANAGEMENT, INC.** a health care plan described hereunder in accordance with the General Provisions indicated at the back hereof. I certify that I supplied personally the information appearing below. I agree that this application becomes binding only upon acceptance and approval by **FIRST GLOBAL PRO HEALTH CARE MANAGEMENT, INC.**, and the subsequent issuance to me of the certificate as proof of cover duly signed by the authorized official/s of **FIRST GLOBAL PRO HEALTH CARE MANAGEMENT INC.**

FULL NAME	**Last**	**First**	**MI**	**Payor** ☐ **Dependent** ☐

RES. ADDRESS: _____ **BUSINESS ADDRESS:**	**TEL. NO.** _____

Height	**Weight**	**Sex**	**Age**	**Occupation**

Place of Birth	**Date of Birth**	**Civil Status**	**Citizenship**

BENEFICIARIES:

NAME	AGE	RELATIONSHIP
1.		
2		

PLAN (Check plan desired)

Global 600	Global 750	Global 900	Global1200	Global1600	Global 2000

PREMIUM AND MODE OF PAYMENT

PREMIUM

INSTALLMENT P _____
Others _____
TOTAL P _____

OR Number _____ **Date** _____
PR Number _____ **Date** _____

MODE OF PAYMENT

	INDIVIDUAL		GROUP
Annual	☐		☐
Semi Annual	☐		☐
Quarterly	☐		☐

DECLARATIONS AND REPRESENTATIONS

I hereby declare to the best of my knowledge and have represented in this application that:

- ❖ I am to the best of my knowledge, in good health.
- ❖ I am not less than 18 years of age nor have attained my 65th birthday.
- ❖ I am in good physical condition and have no physical impairment.
- ❖ I have not been confined in any hospital, infirmary or sanitarium, nor have received medical or surgical treatment for the last 12 months.
- ❖ I have never been treated for cancer, diabetes, heart ailment, high blood pressure, lung, and kidney or stomach disorder.

Please provide details on the space if your answer to any of the above statements reveal otherwise:

Findings: _____
Date of Confinement/Treatment: _____
Name of Doctor_____ Hospital_____

All the provisions of this application contained at the back hereof, together with any rider attached thereto, form part of this agreement and have the same force and effect as if it were set forth on this page.

Signed this _____ day of _____ 20__ at _____, Philippines.

_____ **Signature over Printed Name of Agent**

_____ **Applicant's Signature over Printed Name**

NO._____