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GROUP MEMBERSHIP APPLICATION FORM

Please answer each question fully and truthfully. Print or use typewriter.

Full Name of Proposed Insured			Sex	Civil Status
First Name	M.I.	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
Date of Birth	Place of Birth	Age	Height	Weight
Address (Residence)				
Name of Group				
Present Occupation			Place of Work	

Name of Beneficiary/ies		Date of Birth			Relationship to Proposed Insured
First Name	M.I.	Last Name	Month	Day	

Please answer the following questions completely and indicate all details in the appropriate space.

Details: For "yes" answer to Questions #3 to 5 please give details and duration, symptoms, reason for medical consultation and advice, laboratory tests taken, results, diagnoses, treatment and medication, names and addresses of attending physicians and hospitals/clinics.		
1. Have you ever applied for a new insurance, change in plan or reinstatement of insurance, which was declined, postponed, withdrawn, still pending or modified in kind, amount or rate? If "yes", what insurance company? When? Why?	Yes	No
2. Have you ever engaged in scuba diving, skydiving, racing, mountain climbing, or any hazardous avocation? If "yes", please indicate complete details.		
3. Has there been any death or illness among immediate members of your family? If "yes", please indicate complete details.		
4. Have you ever had or been told to have: a) Any medical problem, illness, disease or sign and symptom of any disease, abnormal bodily growth, injury, physical defects and deformities? b) Any medical advice, consultation, diagnostic test, laboratory examination, treatment, medication and operation/surgery?		
5. Have you ever taken any habit-forming substance or drugs and/or alcoholic drinks, or had the abuse of or treatment for smoking and drinking habit or other addiction?		
6. Have you been active or plan to be active in politics, as a candidate for public office or in any other capacity?		
7. Do you currently or have plans to work or live abroad? If "yes", identify which country and describe nature of work.		
8. If you are a female applicant, are you now pregnant? If "yes", how many months? How many previous pregnancies?		

I hereby apply for participation in the group life insurance plan for which I am or may have become eligible for, subject to the terms and conditions of the Group Policy. I hereby agree that my insurance shall become effective upon approval of the Company provided that I have met all eligibility conditions and am in good health on such date and the full premium corresponding to my insurance coverage has been paid. I hereby declare and agree that all the foregoing statements, declarations and names in this application form together with those stated in any requested medical examination, questionnaire, or amendment, are complete and true and correctly recorded and shall form the basis for Paramount Life & General Insurance Corporation, to determine membership in the Group Life Insurance Plan and which, with the Group Master Policy and its attachments, constitute the entire contract.

Signed at _____ this _____ day of _____

 Signature of Witness

 Signature of Insured

For Home Office Use Only

Group Policy Number	Certificate Number	Effective Date
Plan of Insurance	Insurance Age	Sum Assured