NATCCO Network

STA. CRUZ SAVINGS AND DEVELOPMENT COOPERATIVE

Poblacion Este, Sta. Cruz 2713, Ilocos Sur, Philippines

Reg. No. RI-FF-109 Confirmation No. 362 Re-Reg. no. 9529-01000602

MEDICAIDE

Medical Aid Program

Application Form No.: 05188

Date Accomplished:_____

INSTRUCTIONS:

Please complete this application using CAPITAL LETTERS either in ink or typewriter. All questions must be answered accurately and completely. You should sign and date your application. Application with no signature or date will be returned. A separate Application Form must be completed by each member of the family who is applying for membership. **Application for minors must be signed over printed name by parent or guardian.** Any **MISREPRESENTATION** and/or **CONCEALMENT** of material information that the applicant or his duly authorized representative herein makes shall render his contract **VOID** from the beginning. Receipt of payment by **SACDECO** does not constitute automatic acceptance of the applicant as MEDICAIDE program member. SACDECO reserves the right to reject any application.

APPLICANT'S INFORMATION

It is agreed that SACDECO shall not be liable for any medical bills between the time that I/we accomplished and signed this application and the time of approval of this application.

I hereby agree and undertake as my obligation to obtain from SACDECO MEDICAIDE information and to acquaint myself with all the provisions, terms and conditions of the program.

It is understood that there is no coverage in effect unless after the contestability period of one (1) month.

I/We agree that any deposit I/we sent together with this application shall be returned in case of rejection or disapproval of my/our application.

[ ] NEW [ ] RE-APPLICATION

MEMBERSHIP DATE: | **MEMBERSHIP NUMBER:** | | | | | | | | | | | | |

NAME:

(Family Name) (First Name) (Middle Name)

SEX: [ ] Male [ ] Female | **CIVIL STATUS:** [ ] Single [ ] Married [ ] Widower [ ] Separated | **HEIGHT:**_____ | **WEIGHT:**_____

HOME ADDRESS:

(No., Street, Brgy.) (Town/City) (Province) (Zip Code)

BIRTHDATE: | | | | | | | | **BIRTHPLACE:**

OCCUPATION: | **CONTACT NO.:** | **E-MAIL ADD.:**

BILLING ADDRESS:

(No., Street, Brgy.) (Town/City) (Province) (Zip Code)

OFFICE ADDRESS:

(No., Street, Brgy.) (Town/City) (Province) (Zip Code)

NAME OF PAYOR (for dependents only):

THE PAYOR IS MY: [ ] Husband [ ] Wife [ ] Son [ ] Daughter [ ] Mother [ ] Father [ ] Others | **INITIAL DEPOSIT:**

NAME OF DEPENDENTS	Enrolling? (Pls. encircle)		DATE OF BIRTH (mm/dd/yyyy)	AGE	RELATIONSHIP
1)	YES	NO			
2)	YES	NO			
3)	YES	NO			
4)	YES	NO			
5)	YES	NO			
6)	YES	NO			

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