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

HEALTH DECLARATION FORM

NAME OF APPLICANT:

ADDRESS:

The following questions must be fully answered, otherwise the application will be processed. For the questions that you answered "YES" please provide details of the medical condition including the Diagnosis, Date of First Treatment, Present Course of Treatment, Attending Physician, Hospital, Clinic at the space provided.

	Family Medical History	Age Range	If Alive, State of Health	Age Range	Cause of Death
Father					
Mother					
No. of Brothers					
No. of Sisters					

	YES	NO	Diagnosis	Date of 1st Treatment/ Confinement	Present Course of Treatment	Doctor	Hospital/ Clinic
Brain, Mental or Nervous System							
Lungs or Respiratory System							
Kidney or Urinary System							
Heart Disease of Blood Vessels							
Stomach or Abdominal Organs (Liver/Pancreas/Gallbladder and Colon)							
Disease or Disorder of Skin							
Disease or Disorder of Back, Spine, Joint, Muscles							
Cancer, Tumor or Blood Disorder							
Disease or Disease of Eyes, Ears, Nose, Throat							
Hypertension or High Blood Pressure							
Diabetes Mellitus							
Hernia of Any Kind, Varicocele							
AIDS or HIV Infection							
Any Miscarriage or Complication Of Pregnancy or Delivery							
Any Physical Deformity, Defect, Abnormality							
Chromosomal Disorder (Down Syndrome, Cerebral Palsy Juvenile DM and Mental Development Disorder)							
	YES	NO	Diagnosis	Date of Operation	Surgical Procedure	Doctor	Hospital/ Clinic
Operation or Sergery							

I hereby declare and agree that all statements and answers contained herein and in addendum annexed to this application are full, complete and true and bind all parties to interest under the Agreement herein applied for. That there shall be no contract of health care coverage unless and until the approval of this application and the full Health Savings is actually paid during the good health state of proposed Member. That the health care coverage shall take effect only after One (1) Month contestability Period.

Signed this_____ day of _____, 20____.

Signature of Witness	Signature Over Printed Name of Payor (for minors/if other than the applicant)	Signature of Applicant

SACDECO USE ONLY

_____Approved
_____Deferred
_____For Completion of Application Data
_____For Practical Evaluation
_____Others (Specify) _____
_____Disapproved

FOR THE BOARD OF DIRECTORS

_____
Secretary
Date:_____

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