

**Application for Compulsory Insurance Coverage for AGENCY-HIRED MIGRANT WORKERS
(INDIVIDUAL APPLICATION FORM)**

INSTRUCTIONS: Please ensure that the application form is properly filled out.

WARNING: Direct or indirect commission of fraud, collusion, falsification, misrepresentation of facts, or any other kind of anomaly in the accomplishment of this form, or in obtaining any benefit under this application shall be subject to administrative, civil and/or criminal action.

MEMBER'S PERSONAL INFORMATION

FULL NAME: _____ **Transaction ID:** _____
Last Name _____ First Name _____ Middle Name _____
PRESENT ADDRESS: _____
PROVINCIAL ADDRESS: _____
DATE OF BIRTH (mm/dd/yyyy): _____ **AGE:** _____ **PLACE OF BIRTH:** _____ **GENDER:** _____
CIVIL STATUS: _____ **NATIONALITY:** _____ **E-MAIL ADDRESS:** _____
CONTACT NO.(Telephone): _____ **(Cellphone):** _____ **PASSPORT DETAILS:** **Passport No.:** _____
SSS NO.: _____ **TIN NO.:** _____ **Expiry Date:** _____

DEPENDENT INFORMATION

FULL NAME OF BENEFICIARY/IES	RELATIONSHIP TO INSURED	DATE OF BIRTH	SHARING (OPTIONAL)	REVOCABLE/ IRREVOCABLE
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

NOTE: Unless a special request is made as to the relative share of beneficiary/ies proceeds will be allocated equally among the surviving beneficiary/ies

EMPLOYMENT INFORMATION

NAME OF RECRUITMENT AGENCY: _____
ADDRESS: _____
Employer Name: _____
Employer Address: _____
CONTACT NO. (Telephone/Cellphone): _____ **TERM OF CONTRACT:** _____
COUNTRY OF DEPLOYMENT: _____ **NATURE OF BUSINESS:** _____ **POSITION:** _____
DATE OF EMPLOYMENT (mm/dd/yy): _____

I hereby certify to the truth and completeness of foregoing answers.

Signature over Printed Name of Applicant

**Right Thumbmark
(If unable to affix signature)**

Date

FOR COMPANY USE ONLY
POLICY NO.: _____ **EFFECTIVE DATE:** _____ **CERTIFICATE NO.:** _____
APPROVED BY: _____ **DATE:** _____