PhilFirst NON-LIFE
A Member of PFI Group

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MICRO INSURANCE
KASAPI

Individual Application for KASAPI Microinsurance
(**Kasa**ngga ng **Pi**noy)

PERSONAL DETAILS			
Name of Insured (Family / First / Middle Initial):	Date of Birth:	Gender:	Civil Status:
Occupation:	Height:	Weight:	Contact No.:
Home Address (House No., Street, Barangay/District, Town/City, Province):			

BENEFICIARIES		
Name of Beneficiary/ies	Relationship to Insured	Date of Birth

DECLARATIONS AND REPRESENTATIONS

I hereby apply, for Microinsurance, ~~and~~ represent and declare that:

	YES	NO
1. I am not below 18 years old nor more than 65 years old.	☐	☐
2. I have not consulted a physician for medical attention, treatment, or surgical advice nor have I been confined in any hospital, clinic or similar health institution in the last twelve (12) months.	☐	☐
3. I have not been diagnosed with nor treated for a heart condition, high blood pressure cancer, diabetes, epilepsy, tuberculosis, HIV-AIDS; or lung, kidney, stomach, nervous disorder; or any other ailment in the last five (5) years.	☐	☐
4. I am in good health and physical condition.	☐	☐

Please give details for any NO answers:

Date/s of Confinement/Treatment	Name of Hospital/Clinic/Health Institution	Name of Attending Physician/s	Medical Advice/Diagnosis/Treatment

I attest to the truth and completeness of my declarations and representations above: I understand that ~~those~~ information stated above will be the bases for the evaluation of my application. I agree that PhilFirst Insurance Co., Inc. shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my application for insurance or due to any misrepresentation or concealment in the above statements.

Signature of Applicant: _____ Date: _____
(SIGNATURE OVER PRINTED NAME)

CERTIFICATION

I certify that the Applicant personally appeared before me and completed this Application and that the applicant appeared to be in good health and free from any physical impairments.

Signature of Policyholder's Authorized Representative: _____ Date: _____
(SIGNATURE OVER PRINTED NAME)