APPLICATION FOR PERSONAL ACCIDENT INSURANCE

(All questions must be answered fully. Payment must accompany application)

COVERAGE	Limit of Liability	Annual Premium	(Check One)
Loss of Life, Principal Sum			Executive or Professional
Dismemberment and loss of sight Principal Sum			24 Hr. PA Occupational Class
Bereavement/Burial			Proposed Effective Date
Medical Reimbursement Maximum			Premium to be paid by:
Total Premium			

I hereby apply for a personal accident insurance and declare and warrant that the following statements and answers are full, complete and true and that I have not withheld any information affecting this proposed insurance. I agree that this proposal and declaration shall be the basis of any policy to be issued to me by the GSIS and that any concealment of material mis representation shall render this policy null and void.

1. Name (Print Full Name):

2. Address: Telephone No.

3. Age	Date of Birth	Birthplace	Height	Weight	Sex	Marital Status

4. Occupation Annual Income

State Duties Fully

5. Name of Officer/Employer Telephone No.
Nature of Business
Address

6. Beneficiaries Address Relationship

7. Do you have life accident, disability or hospital insurance now or being applied for? If "yes", what companies, amount and type of coverage. YES ( ) NO ( )

8. Have you ever had any application for life accident, sickness, disability or hospital Insurance declined, postpone, modified, rated up, cancelled or renewal refused? If "yes" state kind of insurance, company, date and reason. YES ( ) NO ( )

9. Is the weekly Indemnity under all policies you have and are applying for less than 75% of your average weekly earnings?
YES ( ) NO ( )

10. Do you contemplate any journey outside Philippines, or any hazardous undertaking? If "yes" give details.
YES ( ) NO ( )

11. To the best of your knowledge and belief:

a) Have you ever had abnormal blood pressure, ulcer, tuberculosis, hernia, diabetis, cancer, syphilis, paralysis, arthritis, rheumatism, any disorder or disease of the mental nervous, genito urinary or digestive system, back spine or heart? YES ( ) NO ( )

b) Have you ever been under medical observation, had medical advice or treatment or been hospitalized during the past five years? YES ( ) NO ( ) If "a" or "b" answer "yes", give complete details.

Nature Period of Disability Doctor/Hospital Result

12. Do you have any physical deformity, impairment of hearing or vision, or loss of hand, foot or vision? If "yes" give details. YES ( ) NO ( )

13. Are you holding an elective office? YES ( ) NO ( )
During the past five (5) years, have you campaigned for or served in any elective position? YES ( ) NO ( )
If "yes", in what capacity?

14. Do you understand and agree that no Insurance will be effective until the Policy is issued? YES ( ) NO ( )

Policy applied for this ________ day of ________________, 20___.