



INDIVIDUAL APPLICATION FOR GROUP TERM LIFE AND HOSPITALIZATION INSURANCE

GENERAL INFORMATION

Last Name		First Name		Middle Name	
Address					
Contact Details: Home		Office	Cell Phone		Fax
Date of Birth (MM/DD/YYYY)		Place of Birth		Age	Sex
		Height	Weight		
Nationality		Citizenship	Occupation		
Source of Fund			SSS/GSIS/TIN		
Name of Employer			Place of Work		

NAME OF BENEFICIARY	DATE OF BIRTH	RELATIONSHIP

I, the proposed life insured individual, declare under the penalty of perjury that to the best of my knowledge and belief the above answers and statements are true, complete and correctly recorded; and agree that, this application, if approved, with the answers given in any other declaration which may be required by Generali Life Assurance Philippines, Inc. (GLAPI) and which relates to the insurability of the proposed life insured individual or to change of this policy coverage, shall be the basis for delivery, change or reinstatement of insurance coverage.

By signing below, I agree that:

1. I understand that the GLAPI is a member of Generali Group and it may have obligations to meet the requirements of both local and foreign regulatory authorities (including local and foreign tax authorities such as the U.S. Internal Revenue Service) as well as other legal obligations relating to information sharing and tax reporting from time to time ("regulatory and legal requirements").
2. All material facts, being facts which might influence the assessment of this Application, have been truthfully, completely and correctly disclosed in this Application and/or any other declaration which may be required by GLAPI, it being understood that my failure to make such disclosure renders the contract void.
3. I consent to the collection, processing, use and storage of information provided to GLAPI and I will provide the information they will request from time to time and allow them to share/report such information with their local and foreign authorities (including local and foreign tax authorities) to meet said regulatory and legal requirement. All medical information given will be uploaded to a medical information database accessible to all insurance companies for the purpose of enhancing risk assessment and preventing fraud.
4. I will notify GLAPI as soon as possible of any change in the information that I have provided to them, including any circumstances such as a change in my residence, address, telephone number and citizenship.
5. I hereby waive any rights I may have that would prevent GLAPI from meeting reporting requirement mentioned above.
6. GLAPI reserves the right to deny claims on the basis of gross fraud or valid grounds recognized under the laws and settled jurisprudence in case of death in any year.

SIGNED AT _____ ON _____

 SIGNATURE OVER PRINTED NAME OF WITNESS

 SIGNATURE OVER PRINTED NAME OF PROPOSED INSURED INDIVIDUAL

"DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud.

Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law.

A copy of Circular Letter 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph"