Your Official Enrollment Form for **Hospital Income Benefit Plan**

10-DAY FREE-LOOK GUARANTEE

Please send me my **Hospital Income Benefit Plan** policy. I understand that this does not obligate me in any way and that I will have the opportunity to inspect my policy for up to 10 days before I accept it. I understand that the insurance will take effect when my policy is issued and I have paid my first premium during my lifetime and good health.

Please Print (Full Name)

☐ Mr. ☐ Mrs. ☐ Ms. [PLEASE TYPE HERE] (First) [ ] (M. I.) [PLEASE TYPE HERE] (Last)

Address [PLEASE TYPE HERE]
[PLEASE TYPE HERE]

Zip Code _____ Mobile No. _____

Tel. No. _____ E-Mail _____

Date of Birth _____ Age _____ ☐ Male ☐ Female

Place of Birth _____

Occupation/Profession _____

Business Address [PLEASE TYPE HERE]
[PLEASE TYPE HERE]

Zip Code _____ Tel. No. _____

Source of Funds _____

TIN _____ GSIS No. _____ SSS No. _____

Please check the plan you require (check one box only):

☐ Plan 500 ☐ Plan 1000 ☐ Plan 2000 ☐ Plan 3000

Indicate the persons to be insured

☐ Yourself ☐ Yourself and your Spouse ☐ Family

Fill out if you wish to enroll your family- *use separate sheet if necessary*

	NAME	AGE	BIRTHDAY
SPOUSE			
CHILDREN aged 3 months to 20 years old			

*Use separate sheet if necessary

Applicant's Signature _____ **Date** _____

(SIGN - DO NOT PRINT)

Credit Card Authorization *(If paying via credit card):*

I authorize Paramount Life to charge my premiums to my credit card

☑ American Express ☐ Bankard / JCB ☐ Diners Club ☐ Any Visa or Mastercard

Cardholder's Name _____

Card Number _____ Tel No./ Mobile No. _____

Expiry Date _____ Amount _____

I hereby understand and agree that should my Credit Card be refused by the Credit Card Company for whatever reason, failing to meet my financial obligation, this premium payment arrangement shall be immediately revoked/cancelled even without prior notice to me. I further agree that Paramount Life shall not be held liable in case of termination of the Policy as a result of such revocation/cancellation.

Cardholder's Signature _____ **Date** _____

(SIGN - DO NOT PRINT)

PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION

Paramount Life & Gen, Madaling kausap.
visit www.paramount.com.ph