Enrollment Form for the
PrimeHealth Cash Plan

Please send me my PrimeHealth Cash 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. ______________________________

First Name *M.I.* *Last Name*

Address ______________________________

______________ Zip Code ________ Res./Off.No. ________

Mobile No. ______________ E-mail Address ______________

Date of Birth ______________ Age ________ ☐ Male ☐ Female

Place of Birth ______________________________

Occupation / Profession ______________________________

Business Address ______________________________

Full Name of Beneficiary ______________________________

☐ *Revocable* ☐ *Irrevocable*

Relationship to You ______________________________

(If there is more than one beneficiary, please write on a separate paper including their relationship to you.)

Tin ______________ GSIS ______________ SSS ______________

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

☐ Plan 50 ☐ Plan 100 ☐ Plan 200 ☐ Plan 300

Other Insurance Policies

Do you have other life insurance policies inforce with other companies?

☐ Yes ☐ No If yes, please provide the details below:

Company ______________________________

Basic/Cover ______________________________

Accident Rider/ Year Issued ______________________________

Is the policy applied for intended to change or replace any existing in force policies?

☐ Yes ☐ No If yes, please complete Replacement Notification Form that we will send you.

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 ☐ Any Visa or Mastercard

____

Cardholder's Name ______________________________

Card Number ______________ Tel 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)

PLEASE INCLUDE YOUR SIGNATURE AND YOUR BIRTHDATE.

Complete and mail • fax • e-mail this form today!

PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION

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