# The Money Shield Plan Enrollment Form


Please send me my **The Money Shield 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**

☐ Mr. ☐ Mrs. ☐ Ms. [PLEASE TYPE HERE] [PLEASE TYPE HERE]

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

Address [PLEASE TYPE HERE]

[PLEASE TYPE HERE] Zip Code Tel. No.

Mobile No. E-mail

Date of Birth Age Ht Wt.

Place of Birth ☐ Male ☐ Female

Occupation / Profession

Specific Duties

Business Address

Zip Code Tel.No.

Full Name of Beneficiary

Relationship to You

☐ *Revocable* ☐ *Irrevocable*

Source of Funds

TIN SSS Number GSIS

**In case of premium default, I elect (check one box only):**

☐ Cash Surrender Option ☐ Extended Term Insurance

*The moment there is a default in premium payment until the end of the grace period provided in the policy and no option has been elected, the Extended Term Insurance option shall automatically take effect.*

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

☐ Plan 100 ☐ Plan 300 ☐ Plan 500 ☐ Plan 1000

**Please check "YES" or "NO" to each question**

1. Have you consulted any doctor for medical treatment, advice for treatment, or been confined in a hospital, clinic or similar institution during the past five years? ☐ YES ☐ NO
2. Have you ever been advised that you had: heart trouble, high blood pressure, cancer, diabetes, epilepsy or tuberculosis? (If "YES", please circle which ailments) ☐ YES ☐ NO
3. Are you aware of any impairment to your health, or physical condition? ☐ YES ☐ NO

**If you answered "YES" to any of the above questions, please give the full details:**
**(Use separate sheet if necessary)**

Person treated Physician's Name

Address Name of Hospital

Date and Nature of Consultation/Sickness/Impairment

*I understand that my Money Shield Plan Policy will be issued based on the above statements which I represent are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, clinic or other medically related facility to furnish PARAMOUNT LIFE & GENERAL INSURANCE CORPORATION with any and all information regarding my medical history and physical condition in connection with this application.*

**Declaration on Existing Policy(ies)**

a. Total Life Insurance inforce on:

Ins. Co. Basic/Cover Accident Rider/ Year of Issue

Proposed Insured:

Applicant/Owner:

*(If different from proposed Insured)*

b. Has there been or will there be any change in any existing insurance inforce?

☐ Yes ☐ No

c. Will premiums for the insurance applied for be paid by a policy loan from any existing policy?

☐ Yes ☐ No If yes, please fumish details (name of company, policy number and amount of insurance being replaced): amount of insurance being replaced):

***Reminder:*** *It is usually disadvantageous to REPLACE existing life insurance policy(ies) with a new one. Some disadvantages are: You may not be insurable on standard terms • You may have to pay a higher premium in view of higher age • You may lose financial benefits accumulated over the years. Please note that in your own interest, we would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.*

**Applicant'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