

Money Shield Plus Enrollment Form



Please send me my Money Shield Plus 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 _____ 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 200 Plan 400 Plan 500 Plan 1000

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

- 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
- 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
- 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 Plus 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 furnish details (name of company, policy number and 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.**
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