GlobalHealth®

Company Application

Proposer's Details

Company Name:

Nature of Business: TIN No.:

List of Directors / Partners:

List of Principal Stockholders owning at least 2% of the capital stock:

Beneficial owners (if any):

Group Administrator Name:

Job Title: Contact No.:

Email:

(Please attach Articles of Incorporation / Partnership and By-Laws)

Location and Contact Details:

Company Address (must be filled in)

Address:

City:

Country:

Telephone: Facsimile:

Email:

Correspondence Address (if different from company address)

Address:

City:

Country: Telephone:

Facsimile: Email:

Plan Selection (please tick relevant boxes)

	A	AA	AAA
	Hospitalisation & Out-patient Surgery only	Hospitalisation & Out-patient Surgery only	Hospitalisation & Out-patient Surgery plus Out-patient
Plan Requested	☐	☐	☐
Area of Cover	☐ Worldwide (only for AA & AAA) ☐ Worldwide excluding North America & the Caribbean		
Annual Deductible	☐ Nil ☐ US$500 ☐ US$1,000 ☐ US$2,000 ☐ US$5,000		
Optional Dental	☐ Yes ☐ No Annual deductible does not apply to the Dental Benefit		
Optional Maternity	☐ Yes ☐ No Maternity Benefit is applicable only to the adult female between 18 and 45 years of age and has selected a AAA Nil Deductible Plan.		

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PIONEER
YOUR INSURANCE

Individuals to be insured: Name (Last, First, Middle)

(Please use separate sheet if necessary. Unless otherwise stated, each individual to be insured must complete a Medical Questionnaire)

Group Eligibility

Employees

Enrolment Requirement	☐ Compulsory ☐ Voluntary
Staff Category to be covered (e.g. senior executives, managers, general staff)	

Dependents

Eligible for Group Cover?	☐ Yes (please complete Enrolment Requirement) ☐ No
Enrolment Requirement	☐ Compulsory ☐ Voluntary

Declaration

I/we hereby apply for a policy to be issued based on the statements contained herein and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. I/We agree to disclose to the Insurer and its medical advisers all material facts and matters of which I/we are aware and execute any document to empower the Insurer to obtain relevant information from any doctor, hospital, or other source. Except as declared herein, all persons to be insured are currently in good health. I/We agree that if the health status of the above intended insured person changes after this application is signed and before the Insurer issues a policy I/We shall immediately notify the Insurer of the change. I/we agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium paid.

Printed Name/Title | Signature | Date | Company Stamp

Contact Person: ______________________ Contact Telephone Number: ______________________

DATA PRIVACY: It is hereby declared that as a condition precedent to the liability of the Insurer, the Insured Individual(s) has agreed that any personal information collected or held by the Insurer is provided and may held, used and disclosed by the Insurer to individuals/organizations associated with the Insurer or any selected third party (within or outside the Philippines) for the purpose of processing the application and providing subsequent services for this and other financial products and services, direct marketing, data matching, and to communicate with the Insured Individual(s) for such purposes. The Insured Individual(s) has the right to obtain access to and to request correction of any personal information held by the Insurer concerning the Insured Individual(s). Such request can be made to Pioneer Life Inc.

NOTE: Under Republic Act 9160 (Anti-Money Laundering Act) as amended by Republic Act 9194 and pertinent regulations, all insurance companies are required to satisfactorily establish the identities of all its customers. Hence, Pioneer Life Inc. reserves the right to not accept and process any application for insurance if the customer fails to provide sufficient evidence to establish his identity.

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PIONEER
YOUR INSURANCE

Payment Options (Please select one)

☐ **Cash (US$ only)**
Please pay in person at Pioneer Head Office, 3rd Floor, 108 Paseo de Roxas St., Legaspi Village, Makati City. Please bring a copy of the debit note(s).

☐ **Bank Transfer**
For direct premium remittances, please send full payment (inclusive of all bank charges) to:

Bank: Banco De Oro
Account Holder: Pioneer Life Inc.
Account No.: 105390-03193-9
Swift Code: BNORPHMM

Note
1. All bank charges (outbound and inbound) will be borne by the remitter
2. Please indicate your Policy Number as payment details to your bank
3. Please email the bank remittance advice or instructions slip with your Policy Number to PLI_cashier@pioneer.com.ph for our accounting records and to issue an Official Receipt

☐ **Credit Card**
Premiums may be paid by Credit Card using the Credit Card Authorization below:

Credit Card Authorization

I/We, the undersigned, authorize you to charge the following credit card for payment of GlobalHealth insurance premiums as stated below:

Policyowner: ______________________________

Policy Number (if known): ______________________________

Phone: ____________________ Email: ____________________

☐ Visa ☐ Mastercard ☐ American Express ☐ JCB

Card Number: ____________________ Expiry Date: ____________________

Card Holder's Name: ______________________________

Issuing Bank: ______________________________

Amount US$: ______________________________

Signature: ____________________ Date: ____________________

Please note: 1. Card payment and effectiveness is subject to credit card centre's approval.
2. Please attach photocopies of the following:
a. front and back of the credit card
b. two (2) valid IDs.

Producer Information (if applicable)

Producer Name: ____________________ Producer Code: ____________________
Address: ______________________________
Phone No.: ____________________ Fax No: ____________________
Email: ______________________________

Please send completed form to:

Pioneer Life Inc.
Attn: GlobalHealth Asia
108 Paseo de Roxas, Legaspi Village,
Makati City 1229, Philippines
Tel: +852 2523 8778 Fax: +852 2526 0769
Email: pliapp@pioneer.com.ph

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