

LIFE PLAN APPLICATION FORM

PRIME / PREMIUM

DSR No.:
Transmittal No.:
Final Contract No.:

Application Date

month day year

Plan Type ☐ PRIME ☐ PREMIUM Type of Sale ☐ INDIVIDUAL ☐ CORPORATE ☐ INSTITUTIONAL ☐ EMPLOYEE

Planholder's Name (Last, First, Middle Names - separate names with commas)

CUSTOMER'S INFORMATION

Planholder's Home Address

House No. /Apt.No. /Lot-Block No.

Street Name

Village / Subdivision

City / Municipality / Province

Zip Code

Business Address

Building Address No.

Street Name

Village / Subdivision

City / Municipality / Province

Zip Code

Planholder's Birthdate

Month Day Year

Civil Status

☐ Single

☐ Married

☐ Widow/er

☐ Separated

Gender

☐ Male

☐ Female

Hgt

Feet Inches

Wgt

Pounds

Occupation

Annual
Income

TIN

SSS
GSIS

Tel.No.

Mobile No.

Email

Spouse's Name (Last, First, Middle Names - separate names with commas)

SPOUSE'S INFORMATION

Spouse's Birthdate

Month Day Year

Occupation

Tel.No.

Mobile No.

Email

Contract Price

Base Value

No. of Units

CONTRACT DETAILS

Mode of Payment

☐ Spot Cash

☐ 5 Year Installment

Mode of Installment

☐ Monthly

☐ Quarterly

☐ Semi-Annual

☐ Annual

Initial Payment Pesos

Regular Installment Pesos

☐ Same as Planholder

Relationship TO Planholder

PAYOR'S INFORMATION

Payor's Name (Last, First, Middle Names - separate names with commas)

Payor's Billing Address

House No. /Apt.No. /Lot-Block No.

Street Name

Village / Subdivision

City / Municipality / Province

Zip Code

Payor's Birthdate

Month Day Year

Civil Status

☐ Single

☐ Married

☐ Widow/er

☐ Separated

Gender

☐ Male

☐ Female

Tel.No.

Mobile No.

Email

Please use a separate sheet for additional beneficiaries information (names, birthdates, relationship to planholder and addresses) if space provided is not adequate.

BENEFICIARY'S INFORMATION

Beneficiary's Name (Last, First, Middle Names)

Birthdate

Relationship
TO Planholder

Address

INSURANCE HEALTH DECLARATION BY PLANHOLDER

I do not know, never had, nor consulted any physician for:

☐ cerebral hemorrhage

☐ undergone any hospitalization
during the past five (5) years

☐ heart disease

☐ cancer or tumor

☐ diabetes

☐ any disease, injury or impairment not
mentioned herein

☐ I have never been declined, accepted substandard, postponed nor
offered a policy different from that applied for.

☐

I possess sound health and able to perform the normal activities in pursuit
of livelihood free from any physical or mental infirmity.

☐

I understand and agree that the insurance of this application is based on the
insurance declarations appearing hereon, and is subject to the provisions under
the group life insurance policy to be issued to Loyola Plans Consolidated, Inc.
by a reputable life insurance company, licensed to carry on business in the
Philippines.

EXCEPTIONS:

Signature of Planholder

SOC Code

Mode of Correspondence: ☐ Mail or Courier

☐ SMS (Text)

☐ Email

Loyola documents to be sent via: ☐ Mail ☐ Pick-up

Final Contract and Billing Notices to be sent to : ☐ Planholder ☐ Payor

BUSINESS MANAGER (Signature over printed name)

Encoded by:

Verified by:

Signature over printed name

Date Encoded

Signature over printed name

Date Verified

Note: After two (2) years of lapsation, the lifeplan's termination value shall be used as part of the memorial service budget at any Loyola Accredited Memorial Chapel.