APPLICATION FORM

A.General Questions

Proposed Insured's Name:
(Please use capital letters)

Birth Date: ____/____/____ Gender: ☐ Male ☐ Female

Address: _____

Phone Number: _____ Email Address: _____

ID Number: _____ Social Security Number: _____

Status: ☐ Single ☐ Married ☐ Devorced ☐ Others

Occupation: _____ Are you a retiree? ☐ Yes ☐ No

B.Type of Health Coverage

Employee: ☐ Yes ☐ No Plan Choice:	Spouse: ☐ Yes ☐ No Plan Choice:	Children: ☐ Yes ☐ No Plan Choice:

Complete If Spouse/Children are Proposed for Insurance:

Name	SSN No.	Relationship to proposed insured	Birth Date	Age	Sex

C.The Policy

Units _____ Annual Premium: _____

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Monthly PAT (complete PAT card)

Cash with Application: $ _____

Planned modal premium: $ _____

Terms & Conditions
Improvement should be measured regularly and assessed in order for you to know what's beneficial and what is not. This will help you set new targets.

Signature:

Date: _____