Ang produktong PNPCare Health Card ay handog ng PSSLAI upang mapangalagaan ng lubos ang inyong kalusugan. Ang FortuneCare ang katuwang ng PSSLAI sa proyektong ito.

Nais naming ipabatid na ang PSSLAI ay instrumento para sa **GROUP REPRESENTATION** upang makakuha ng pinakamagandang serbisyo sa napakababang presyo sa PNPCare Health Card samantalang ang FortuneCare ang magbibigay ng aktwal na serbisyo para sa inyong pangangailangan pangkalusugan. Samakatuwid, lahat ng katanungan at impormasyon tungkol sa serbisyong medikal ay dapat iparating sa FortuneCare. Maaari silang tawagan sa numerong (Provincial Toll Fee No. 1-800-10-633-888-8/Manila 637-4229) o pagpapadala ng text message sa 0928-503-6766

AUTHORIZATION

Ako, ______________________________ ay malayang nagbibigay ng pahintulot sa PSSLAI na ibawas mula sa aking loan proceeds o di kaya ay sa aking Capital/Premium Savings Account ang halagang (__________) bilang annual premium para sa aking(at aking mga dependents) PNPCare Health Card.

Nais ko rin na kumuha ng PNPHealth Card para sa mga dependents na sina:

Pangalan	Relasyon	Kapanganakan	Annual Premium
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

WAIVER

This is to confirm NO OBJECTION for the deposit of check/checks payable to me to the account of Fortune Medicare Inc. with account no. 00520-000108-6

Check details as follows:
RCBC Makati Ave. Date: ______________
Check No.________________ Payee:______________
I confirm waiver to these checks which shall be deposited in the account of FORTUNE MEDICARE, INC.

Signature:
Printed Name:
Address:
Contact No.:

Ang produktong PNPCare Health Card ay handog ng PSSLAI upang mapangalagaan ng lubos ang inyong kalusugan. Ang FortuneCare ang katuwang ng PSSLAI sa proyektong ito.

Nais naming ipabatid na ang PSSLAI ay instrumento para sa **GROUP REPRESENTATION** upang makakuha ng pinakamagandang serbisyo sa napakababang presyo sa PNPCare Health Card samantalang ang FortuneCare ang magbibigay ng aktwal na serbisyo para sa inyong pangangailangan pangkalusugan. Samakatuwid, lahat ng katanungan at impormasyon tungkol sa serbisyong medikal ay dapat iparating sa FortuneCare. Maaari silang tawagan sa numerong (Provincial Toll Fee No. 1-800-10-633-888-8/Manila 637-4229) o pagpapadala ng text message sa 0928-503-6766

AUTHORIZATION

Ako, ______________________________ ay malayang nagbibigay ng pahintulot sa PSSLAI na ibawas mula sa aking loan proceeds o di kaya ay sa aking Capital/Premium Savings Account ang halagang (__________) bilang annual premium para sa aking(at aking mga dependents) PNPCare Health Card.

Nais ko rin na kumuha ng PNPHealth Card para sa mga dependents na sina:

Pangalan	Relasyon	Kapanganakan	Annual Premium
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

WAIVER

This is to confirm NO OBJECTION for the deposit of check/checks payable to me to the account of Fortune Medicare Inc. with account no. 00520-000108-6

Check details as follows:
RCBC Makati Ave. Date: ______________
Check No.________________ Payee:______________
I confirm waiver to these checks which shall be deposited in the account of FORTUNE MEDICARE, INC.

Signature:
Printed Name:
Address:
Contact No.:

PUBLIC SAFETY SAVINGS AND LOAN ASSOCIATION (PSSLA) INCORPORATE

Application for 2009 HMO Coverage

I hereby apply for FortuneCare Healthcare Program membership and agree that I shall abide by the provisions of the membership agreement and FortuneCare regulations to which I commit, agree and undertake to be bound by the conditions thereof. I understand that there shall be no coverage in effect unless my application is processed and approved by FortuneCare and membership card is issued and hence, that FortuneCare will not be liable for any medical bills between from the time that I sign this application form and effective date of coverage is approved and membership cards issued and delivered to me.

PART I — **YOUR PERSONAL DATA**

NOTE: TO FACILITATE PROCESSING OF THIS APPLICATION, PLEASE ACCOMPLISH THIS FORM IN FULL. KINDLY WRITE IN BLOCK LETTERS AND CHECK THE APPROPRIATE BOX WHERE APPLICABLE.

PRINCIPAL/PAYOR						
			mm dd yy			
LASTNAME	FIRSTNAME	MIDDLE NAME	DATE OF BIRTH	AGE	SEX	CIVIL STATUS

Region ______________________ Telephone No./ Local ______________________

Branch ______________________ Mobile Number ______________________

QUALIFIED DEPENDENTS									
FULL NAMES OF DEPENDENTS (ALL) (Arrange Name Chronologically Based on Age)		IF APPLYING (Please encircle)		RELATION TO THE PAYOR	AGE	SEX	CIVIL STATUS	BIRTHDAY (MM-DD-YYYY)
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					
		YES	NO					

PART II — **CONDITIONS OF ENROLLMENT**

- Unless my application is processed and approved by the Underwriting Department of Fortune Medicare,Inc. will not be eligible for coverage.
- I understand that neither my family nor I wil be eligible for benefits should there be false or withheld data, and that my dependents' coverage may be revoked based on misrepresentations or non-disclosure.
- I understand that the enrollment for qualified dependents should follow hierarchy or prioritization as follows:

1. **FOR MARRIED MEMBERS:**

   First Priority - Legal Spouse, 18 years old up to 65 years old, as of last birthday

   Second Priority - Eldest child, second eldest child and so on, 3 months old and not over 21 years old as of last birthday Single and unemployed

2. **FOR SINGLE MEMBERS:**

   Parents up to 65 years old, as of last birthday; siblings at least 3 months old but not over 21 years old as of last last birthday (parents must be enrolled first followed by eldest brother/sister and so on)

3. **FOR SINGLE PARENTS:**

   Children from 3 months and not over 21 years old; Hierarchy must be followed: Eldest child, second eldest Child and so on

IN WITNESS WHEREOF, I have hereunto affixed my signature this __________________day of ______________ 2008 in ___________________, Philippines.

____

(Signature over printed name of applicant)

BACK PAGE

NOTE:

- Parents of single member below 65 years old will be considered as Qualified Dependents *(QD); in case of hospitaliz*
  and no Philhealth form is filed, member will pay the Philhealth portion of the hospital bill and professional fee.
- *All Employee, Dependents and Extended Family Member* must file claim for Philhealth during confinement, ol
  members will pay Philhealth portion of the hospital bill and professional fees.

I hereby declare that the foregoing statements are true and correct to the best of my knowledge and ability.

IN WITNESS WHEREOF, I have hereunto affixed my signature this _______________day of ____________
2008 in _________________, Philippines.

____

(Signature over printed name of applicant)