



COCOLIFE Building 6807 Ayala Avenue Makati City 1226
Tel. No. 812-9015 Fax No. 812-9039 / 812-9040



**APPLICATION FOR
COMPULSORY INSURANCE COVERAGE FOR AGENCY-HIRED MIGRANT WORKERS**

YOUR PERSONAL INFORMATION

NAME : Mr. Ms. Mrs.

Philippine Address : _____
Last Name First Name M.I.

Civil Status : Single Married Separated Widow/er

Birthdate : _____ Birthplace : _____
TIN : _____ - _____ - _____ Age : _____
Telephone : Home : _____ - _____ Office : _____ - _____
Fax : _____ - _____ Mobile : _____ - _____
Email Address : _____

YOUR PASSPORT DETAILS

Name(as it appears on your passport) : _____
Last Name First Name Middle Name
Passport No. : _____ Issued on: _____ at: _____

YOUR AGENCY

Agency Name : _____
Address : _____
Association : _____
Contact Nos. : Tel. : _____ - _____ Fax : _____ - _____
email : _____ Agent : _____

YOUR WORK

Company Name : _____
Address : _____
Nature of Business : _____ Country : _____
Designation : _____ Industry : _____
Monthly Compensation: _____ Currency: _____
T.O.C. : From _____ To _____ Contract Yr: _____

YOUR BENEFICIARY(IES)

It is understood that the beneficiaries share equally and are designated primary and revocable unless indicated otherwise in the "REMARKS" column.

NAME	RELATIONSHIP	DATE OF BIRTH	REMARKS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby represent and declare that:
 a) I am not below 18 years old and have not reached 61 years of age; and
 b) I possess sound health and am able to perform normal activities in pursuit of my livelihood free from any physical and mental infirmity.

I hereby agree that the above questions and answers shall be considered as part of my application for insurance.
 I hereby declare that all the foregoing answers and statements are complete, true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT

DATE