



PUBLIC SAFETY MUTUAL BENEFIT FUND, INC

No. 318-320, Santolan Rd., Cor 1st and 2nd West Streets, San Juan, Metro Manila

Tel No 726-1675; 726-8070 TeleFax 726-7250; 725-4725

E-Mail customercare@psmbfi.com.ph

MEMBERSHIP APPLICATION FORM

Office Copy

Please print or type all information on the spaces provided.

Date Received _____

<input checked="" type="checkbox"/> Last Name	<input checked="" type="checkbox"/> First Name	<input checked="" type="checkbox"/> Middle Name	<input checked="" type="checkbox"/> Qualifier	<input checked="" type="checkbox"/> Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
---	--	---	---	--

<input checked="" type="checkbox"/> Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Widow/er <input type="checkbox"/> Married <input type="checkbox"/> Separated	<input checked="" type="checkbox"/> Height (ft)	<input checked="" type="checkbox"/> Weight (lbs)	<input checked="" type="checkbox"/> Date of Birth (MM/DD/YY)	<input checked="" type="checkbox"/> Age	<input checked="" type="checkbox"/> Distinguishing Marks
---	---	--	--	---	--

<input checked="" type="checkbox"/> Home Address _____	<input checked="" type="checkbox"/> Place of Birth _____
--	--

<input checked="" type="checkbox"/> e-Mail Address _____	<input checked="" type="checkbox"/> Cell Phone No. _____	<input checked="" type="checkbox"/> GSIS/SSS No. _____	<input checked="" type="checkbox"/> Pag-ibig No. _____
--	--	--	--

<input checked="" type="checkbox"/> Public Safety Agency <input type="checkbox"/> Philippine National Police <input type="checkbox"/> Bureau of Jail Management and Penology <input type="checkbox"/> Bureau of Fire Protection <input type="checkbox"/> Others (Pls Specify) _____	<input checked="" type="checkbox"/> Account Number
--	--

<input checked="" type="checkbox"/> Rank	<input checked="" type="checkbox"/> Present Assignment (Unit / Address) _____	<input checked="" type="checkbox"/> Office Phone No.
--	---	--

<input checked="" type="checkbox"/> Date Entered Service (MM/DD/YY)	<input type="checkbox"/> Uniformed Personnel <input type="checkbox"/> Non-Uniformed Personnel
---	---

<input checked="" type="checkbox"/> For Non-Uniformed Personnel / Civilian (Pls check one option)									
Contribution	Sum Assured	Contribution	Sum Assured	Contribution	Sum Assured	Contribution	Sum Assured	Contribution	Sum Assured
<input type="checkbox"/> P 50	P 26,923.07	<input type="checkbox"/> P 300	P 161,538.46	<input type="checkbox"/> P 600	P 323,076.92	<input type="checkbox"/> P 900	P 484,615.38	<input type="checkbox"/> P 1,000	P 538,461.53
<input type="checkbox"/> P 100	P 53,846.15	<input type="checkbox"/> P 400	P 215,384.62	<input type="checkbox"/> P 700	P 376,923.08				
<input type="checkbox"/> P 200	P 107,692.31	<input type="checkbox"/> P 500	P 269,230.77	<input type="checkbox"/> P 800	P 430,769.23				

<input checked="" type="checkbox"/> Designated Beneficiaries						Special Group Insurance (SGTI)	Basic Group Term (BGTP)	Burial Assistance Benefit (BAB)
Name (First, Middle, Last, Qualifier)	Relationship to the Insured Member	Birth Date	Percent Share (Total must be 100%, if not, will be distributed equally)	Remarks				
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

All beneficiary designations are deemed revocable unless indicated otherwise. (Please use the back portion for additional beneficiaries.)

<input checked="" type="checkbox"/> Health Statements:	YES	NO
a. Have you ever been treated for or been advised by a licensed physician that you have any of the following diseases: Heart, Lung, Nervous, or Kidney Disorder, Hypertension, Diabetes, Cancer or any malignant tumor?	_____	_____
b. Do you have any medical condition not stated above? Please specify: _____	_____	_____
c. Have you been hospitalized, or have been treated by a physician for any reason during the last five (5) years?	_____	_____
d. Are you in good health and free from any physical impairment, deformity or disease?	_____	_____

Certification / Authorization

I hereby declare that all statements and answers contained herein are true, complete and correct to the best of my knowledge and belief, and shall form part of my application for Insurance. It is understood and agreed that this Insurance coverage shall take effect on the first day of the month for which the payroll deduction is made, if the payment of contribution is made thru Automatic Salary Deduction or the actual date of payment of first contribution, if directly paid to PSMBFI.

I further authorize PSMBFI to secure from any government office such as the Philippine National Police (PNP) and the National Statistics Office (NSO), any or all information and documents relating to my membership, such as but not limited to Birth Certificate (member and beneficiaries), Marriage Contract (member and beneficiaries), Service Records (member) and Advisory on Marriage (member and spouse).

_____ Member's Signature

_____ Date