BPI/MS Insurance Corporation

A joint venture of the Bank of the Philippine Islands & Mitsui Sumitomo Insurance

Travel Care Insurance Reply Form

PROTECT YOURSELF WITH BPI/MS TRAVEL CARE INSURANCE!

ABOUT MYSELF *(Please print clearly)*

☐ Mr. ☐ Ms. ☐ Mrs.

Name _____
(Family Name) *First Name* *MI)*

Civil Status: _____ Date of Birth: _____
(mm/dd/yy)

Age: _____ Sex: _____ Weight _____ Height _____

Residential Address: _____
(No. Street Subd./Barangay Village/City/Town Zipcode)

Office Address: and Name of Employer: _____
(No. Street Subd./Barangay Village/City/Town Zipcode)

Nature of Business / Occupation / Designation: _____

Net Annual Income: _____

Name of Beneficiary / Relationship: _____

Period of Insurance: _____ Months _____ Days

From _____ To _____

Journey: From _____ To _____

Via Air Travel — Airlines / Flight _____

Sea Travel — Vessel _____

Land Travel — Mode of Transportation _____

Purpose of Travel: _____

Type of Plan

Domestic	☐ 500,000	☐ 1,000,000	☐ 2,000,000
Non - Schengen *(Asia, America & Other Non European Union Countries)*	☐ 1,000,000 *(Gold)*	☐ 2,000,000 *(Diamond)*	☐ 3,000,000 *(Platinum)*
Schengen *(European Union Member Countries)*	☐ 1,000,000 *(Gold)*	☐ 2,000,000 *(Diamond)*	☐ 3,000,000 *(Platinum)*

Email address:

BIR TIN:

Cell Phone #:

Mailing Address (for LBC):

OTHER INFORMATION *(Please print clearly)*

	YES	NO
Do you have any other life, accident or medical insurance at present? If yes, please provide details _____	☐	☐
To the best of your knowledge and belief have you ever been treated or been told you have heart disease, epilepsy, sexually transmitted disease, diabetes, renal disease, injury to/disease of the spine or sacro-iliac joint, or mental/nervous disorder? If yes, please provide details _____	☐	☐
To the best of your knowledge and belief, have you ever been disabled, have suffered from any disease or received any medical/surgical treatment or advice during the past five years? If yes, please provide details _____	☐	☐
Do you have any deformity, impairment of hearing or vision, or loss of hand, foot or vision? If yes, please provide details _____	☐	☐

Note: This Application, if approved, shall form part of and shall be the sole basis in issuing the Personal Accident Insurance Policy. Any material fact disclosed or misrepresented at the time this Application is accomplished, shall exempt the Insurer from any liability caused or brought about by such undisclosed or misrepresented material fact.

Date	Signature of Applicant *(Over Printed Name)*	Signature of Agent/Sales Office *(Over Printed Name)*

Additional Questions:

Are you an existing BPI client? (With Savings account / credit card / loan) Yes or NO