Insular Health Care, Inc.
Insular Health Care Building, 167 Dela Rosa corner Legazpi Streets,
Legazpi Village, Makati City 1229, Philippines
(632) 813-0131 (632) 813-7856
inquiry@insularhealthcare.com.ph
http://www.insularhealthcare.com.ph

APPLICATION FOR REINSTATEMENT OF INDIVIDUAL MEMBERSHIP

PLEASE WRITE LEGIBLY IN BLOCK LETTERS. FILL OUT ALL BLANKS / BOXES OF THIS APPLICATION AND ITS ATTACHMENT, WHERE APPLICABLE, AND SUBMIT THEM TO INSULAR HEALTH CARE AS SOON AS POSSIBLE. ONLY COMPLETELY FILLED-OUT APPLICATION WITH COMPLETE REQUIREMENTS, IF ANY, WILL BE PROCESSED.

PART I – PERSONAL INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME	SEX

HOME ADDRESS NO.	STREET	TOWN/BARANGAY	CITY/MUNICIPALITY	ZIP CODE

AGE	DATE OF BIRTH	CIVIL STATUS	RESIDENCE TEL. #	E-MAIL ADDRESS

EFFECTIVE DATE	DUE DATE	DATE OF LAST PAYMENT	O.R. NO.

PART II – MEDICAL INFORMATION

1. During the last twelve (12) months, have you been treated by a physician or confined in a hospital? ❑ **YES (give details)** ❑ **NO**

NAME [PRINCIPAL / DEPENDENT]	DATE	ILLNESS	HOSPITAL	PHYSICIAN

Use back page for more entries

2. During the last twelve (12) months, have you had any symptoms and / or medical conditions which have not been referred to or treated by a physician? ❑ **YES (give details)** ❑ **NO**

_____

_____

3. Please list down drugs or medicines you are currently taking:

TYPE OF DRUGS	HOW OFTEN

I acknowledge:

- That any misrepresentation or omission of important medical information, knowing or unknowingly, shall render my membership null and void.
- That Insular Health Care shall not be liable for any medical expense during the time my membership is lapsed.
- That my application will be medically underwritten subject to acceptance or denial as the case may be.
- That any payment I make for my lapsed policy shall be considered as **"deposit"** for reinstatement of coverage. I acknowledge that my payment should be made either at the Head Office or at any of the Insular Health Care branch offices nationwide; or to a bonafide agent (whose provisional receipt will be replaced with an official receipt upon remittance to the Head/Branch Office of Insular Health Care).

_____ _____

Printed Name and Signature of Applicant/Parent/Legal Guardian/Payor **Date Signed**

FOR HOME OFFICE USE

❑ **APPROVED** ❑ **HOLD** ❑ **DISAPPROVED**

REMARKS: _____

_____

EVALUATED BY: _____ **DATE:** _____
Medical Services and Evaluation Assistant

APPROVED BY: _____ **DATE:** _____
Manager, Medical Services

It's Our Nature to Care!

Kalingang Insular Health Care