Commonwealth Insurance Company

Head Office: 10th & 19th Floor BDO Plaza, 8737 Paseo de Roxas, Makati City
Phone: (02) 818-7626 to 31 ● Fax: (02) 813-8575 ● Email: info@cic.com.ph
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Personal Accident Insurance Application Form

Plan Desired: ☐ Regular Plan ☐ Family Plan ☐ Executive Plan

Amount of Cover Desired:_____

Full name:_____

Address:_____

Landline No.:_____ Mobile No.:_____ Email Address:_____

Gender:_____ Age:_____ Birth Date:_____ Birth Place:_____

Height:_____ Weight:_____ Marital Status: ☐ Single ☐ Married ☐ Widow/er

Occupation:_____ Annual Income:_____

State Duties Fully:_____

Name of Employer:_____ Nature of Business:_____

Employer's Address:_____

Phone Number:_____

Beneficiary

1._____ Relationship:_____

Address:_____

2._____ Relationship:_____

Address:_____

3._____ Relationship:_____

Address:_____

	Yes	No
1. Do you operate or ride any two-wheeled motor vehicle?	☐	☐
2. Are you holding an elective public office?	☐	☐
3. During the past five (5) years, have you campaigned for or served in any elective position? (If yes, when & in what capacity)	☐	☐
4. a. Are you planning any journey outside the country or any hazardous activities? (If yes, give details) b. Average flying hours per year:_____	☐	☐
5. Are you planning to engage or are you engaged in any sports/activities like hunting, polo, horse racing,water skiing, skin diving, scuba diving, football, soccer, motor racing, mountaineering, land & ice hockey, bob diving, sled driving, yachting or private flying as a pilot? (If yes, please underline or state the sports/activities) _____	☐	☐
6. Do you have any physical deformity, impairment of hearing or vision, or loss of hand, foot or vision? (If yes, give details)	☐	☐
7. Have you ever had abnormal blood pressure, ulcers, tuberculosis, hernia, diabetes, cancer, syphillis, paralysis, arthritis, rheumatism, any disorder or disease of the mental, nervous, genito-urinary or digestive systems, back, spine or heart?	☐	☐
8. Have you ever been under medical observation, had medical advice or treatment, or have been hospitalized during the past five (5) years?	☐	☐
9. Do you have life, accident, disability or hospital insurance now or being applied for? (If yes, what companies, amount and type of coverage)	☐	☐
10. Do you have life, accident, disability or hospital insurance declined, postponed, modified, rated up, cancelled, or renewal refused? (If yes, state kind of insurance, company, date, and reasons)	☐	☐
11. Do you understand and agree that no insurance will be effective until the policy is issued?	☐	☐

*** If your answer in item no. 7 or 8 is yes, please give complete details. (Nature, Period of Disability, Doctor/Hospital, Result)

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I hereby apply for a personal accident insurance and declare and warrant that the following statements and answers are full, complete and true and that I have not withheld or concealed any information affecting this proposed insurance. I agree that this proposal shall be the basis of any policy to be issued to me by the Company and that any concealment or material misrepresentation shall render this policy null and void.

Applicant's Signature _____

Application Date _____

Agent:_____