KNIGHTS OF COLUMBUS FRATERNAL ASSOCIATION OF THE PHILIPPINES, INC. (KCFAPI)
KCFAPI Center
Gen. Luna corner Sta. Potenciana Streets, Intramuros, Manila, Philippines
Tel. Nos. 527-2223 to 27 * TIN: 001-007-909

FM-KCFAPI-FBG-07
REV. DATE. 9/1/2014

APPLICATION FOR BENEFIT CERTIFICATE (BC)

PLEASE USE BLACK INK, WRITE LEGIBLY IN BLOCK LETTERS AND CHECK THE APPROPRIATE BOX ☐ WHERE APPLICABLE

PART I. PERSONAL INFORMATION

	Proposed Assured	Owner/Payor
1. Full Name	Surname / First Name / Middle Name	Surname / First Name / Middle Name
2. Date of Birth	mm/dd/yyyy / Age	mm/dd/yyyy / Age
3. Place of Birth		
4. Gender & Civil Status	☐ Male ☐ Female ☐ Single ☐ Married ☐ Widow/er	☐ Male ☐ Female ☐ Single ☐ Married ☐ Widow/er
5. TIN/SSS/GSIS		
6. Nationality		
7. Mailing Address	#/Street Brgy/Town City/Province ZIP CODE	#/Street Brgy/Town City/Province ZIP CODE
8. Occupation	☐ Employed ☐ Self-Employed	☐ Employed ☐ Self-Employed
Specific Duties		
Name of Firm/Employer		
Work/Business Address		
Nature of Business		
9. Contact #/Info	Residence / Work / Business Mobile / Email	Residence / Work / Business Mobile / Email
10. Council Membership	**FOR MEMBERS** Council Name/Address Council # Date of Initiation to the First Degree mm/dd/yyyy Degree at Present Are you at present a member of good standing? ☐ Yes ☐ No	**FOR RELATIVES OF MEMBERS ONLY** Relationship with the member Knight: I am the ☐ Father ☐ Mother ☐ Son ☐ Daughter ☐ Wife of Bro. Council Name/Address Council #

PART II. INSURANCE INFORMATION

11. Plan Details	Plan Name		Plan Code	Face Value	Currency ☐ Peso ☐ US Dollar
	No. of Years to Contribute	Years of Protection	Years to Mature	Modal Contribution (default annual) ☐ Annually ☐ Semi-annually ☐ Quarterly	Amount of Contribution (at standard rate)
12. Additional Benefits	☐ Accidental Death Benefit ☐ Waiver of Contribution ☐ Payor's Death or Disability Benefit ☐ Others _____				
13. Contribution Default Option	*If contribution remains unpaid at the expiry of the grace period, apply cash value, if any, to effect:* *(If no option is chosen, PUI will apply)* ☐ Automatic Contribution Loan (ACL) ☐ Paid-Up Insurance (PUI) ☐ Cash Value (CV)				
14. Participation Options	*I desire my annual participation to be:* ☐ Paid in Cash ☐ Left to accumulate at interest** ☐ Used to reduce insurance contributions* *In case the BC becomes fully paid, for which no more contributions will become due, or in case there is no outstanding BC loan, annual participations will be left to accumulate at interest. **KCFAPI is authorized to use any accumulated participations to pay any unpaid contribution before the application of Automatic Contribution Loan Option, if Automatic Contribution Loan Option is chosen in Item 13 of this application. KCFAPI is also authorized to apply any accumulated participations to cover any outstanding certificate loan prior to exhaustion of the cash value of the Benefit Certificate and the cash value of any paid-up additions. *(If no option is chosen, used to reduce insurance contributions will apply)*				
15. Beneficiaries Name	☐ Revocable ☐ Irrevocable				

(Primary) Name	Date of Birth mm/dd/yyyy	Relationship to Proposed Assured	(Contingent) Name	Date of Birth mm/dd/yyyy	Relationship to Proposed Assured

Use additional sheet(s) if necessary.

DECLARATION REGARDING PROPOSED ASSURED AND OWNER/PAYOR

	16. Do you have other Benefit Certificates with KCFAPI? If yes, please indicate details below			17. Do you have life, accident, or group insurance with other companies? If yes, please indicate details below			
	Benefit Certificate No.	Year Issued	Face Value	Company	Year Issued	Face Value	Type of Insurance
Proposed Assured							
Owner/Payor							

ENDORSEMENT OR AMENDMENTS (for home office use only)

If you answered YES to any of the following questions, please provide details to space provided below. Use additional sheet(s) if necessary.	Proposed Assured		Owner/Payor	
	Yes	No	Yes	No
18. Will existing insurance with KCFAPI be discontinued if insurance now applied for is issued? If yes, please state reasons.	☐	☐	☐	☐
19. Do you drive a motorcycle? If yes, please state how often and for what purpose.	☐	☐	☐	☐
20. Are you engaged in auto/motorboat racing, sky/scuba diving or other hazardous avocations? If yes, please specify.	☐	☐	☐	☐
21. Do you intend to ride an aircraft other than as a passenger in a commercial passenger airline? If yes, please give details.	☐	☐	☐	☐
22. Are you now or do you intend to be enlisted with the military, naval or air force service other than as a reserve? If yes, please state rank and place of assignment.	☐	☐	☐	☐
23. Do you have any pending application for life insurance or accident insurance? If yes, please state companies and amount of insurance.	☐	☐	☐	☐
24. Have you made an application for life insurance, or for reinstatement for a life insurance policy with other insurance company/ies which was declined, postponed, cancelled or modified in terms of the plan, amount or rate? If so, please state companies, causes and dates.	☐	☐	☐	☐

DETAILS:

DECLARATION AND AGREEMENT

I declare and agree:

1. That my insurance membership with KCFAPI, or my insurance under the Benefit Certificate now applied for, or both, shall not be effective nor become valid unless and until this application has been approved and the first contribution payment on the certificate has been made, and provided further that there has not been any change in my health and insurability since the date of this application or medical examination, if applicable.
2. That I bind myself to communicate to KCFAPI any change in my health condition or occupation as stated in the application, before accepting delivery of the Benefit Certificate and paying the first contribution.
3. That the Articles of Incorporation and By-Laws of KCFAPI and the Charter Constitution and laws of the Knights of Columbus of which I am a member, which are now inforce or which may be in the future be made or adopted, shall be binding upon me and my beneficiary.
4. That the decision of the Board of Trustees of KCFAPI or of their successors in office shall prevail in all matters of dispute between KCFAPI or its members and myself, relative to membership or the obligations of membership.
5. That I have read this page of my application in its entirety and that all statements and answers made by me are true and correct to my knowledge, belief and based on official documents. I further agree that I and my beneficiaries or anybody claiming in my behalf, are bound by the provisions of this application, which is the sole basis upon which KCFAPI shall issue a Benefit Certificate to me.
6. While the Proposed Assured is still a minor, all rights and privileges under the Benefit Certificate shall be exercised by the Payor, who shall likewise be the Owner.

Signed at_____this _____day of _____, 20 _____.

_____
Signature of Proposed Assured over Printed Name

If Proposed Assured is below 18 years old, owner/payor must also sign below:

_____
Signature of Owner/Payor over Printed Name

FRATERNAL COUNSELOR'S (FCs) CERTIFICATION

I personally saw the Proposed Assured/Applicant and that I certify that I have read and explained each question in this page to him/her and that his/her answers are recorded exactly as given and that I know nothing adverse to the risk that is not recorded in this page. Likewise, I have seen the applicant's Identification Card/s which number/s is/are accurately represented in the application form.

Application solicited by FC:

_____ _____
Signature of FC over Printed Name FC Code No.

_____ _____
Signature of Area/ Unit Manager Area Name and Code No.

Note: *FC must also file "FCs Confidential Report on Applicant" at the back of this page, whether this application is medical or non-medical*

AUTHORIZATION TO MY ATTENDING PHYSICIAN

This portion (or photostatic copy of it) authorizes you to give the Knights of Columbus Fraternal Association of the Philippines, Inc., any or all information you may have regarding my condition when under hospitalization, consultation, treatment or any other medical advice or examination by you, including the history obtained, findings and diagnosis. This authorization is in connection with my application for insurance and all claims arising therefrom.

_____ _____
Signature of Proposed Assured over Printed Name Date Signed

If Proposed Assured is below 18 years old, owner/payor must also sign below:

_____ _____
Signature of Owner/Payor over Printed Name Date Signed

Note: *This authorization must be signed whether this application is medical or non-medical*

KNIGHTS OF COLUMBUS FRATERNAL ASSOCIATION OF THE PHILIPPINES, INC.
P.O. Box 510 CPO Manila; Tel No.: (02) 527-2223 to 27; Fax: 527-2235

DECLARATION ON THE PROPOSED REPLACEMENT BENEFIT CERTIFICATE / POLICIES

A. For The Applicant to Answer

1) Has there been or will there be any change in any existing insurance in-force? ☐ Yes ☐ No
2) Will contributions for the insurance applied for be paid by a certificate/policy loan from any existing certificate/ policy? ☐ Yes ☐ No
3) If yes, please furnish details (name of company, certificate/policy number, and amount of insurance being replaced) _____

B. For the Fraternal Counselor / Agent to Answer

1) Has there been or will there be any change in any existing insurance in force on the life of Proposed Assured? ☐ Yes ☐ No
2) Will contributions for the insurance applied for be paid by loan from any existing Benefit Certificate/Policy? ☐ Yes ☐ No

REMINDER It is usually disadvantageous to REPLACE existing life insurance policy(ies) or Benefit Certificate(s) with a new one. Some of the disadvantages are:

- *You may not be insurable on standard terms*
- *You may have to pay a higher contribution in view of higher age.*
- *You may lose financial benefits accumulated over the years*

Please note in your own interest, we would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

_____ _____
Signature of Fraternal Counselor over Printed Name Date Signed

PART III. NON-MEDICAL AND PERSONAL HISTORY (FAMILY AND CLINICAL HISTORY)

1. Family Record				Living		Deceased	
A. Proposed Assured	Surname	First Name	M.I.	Age	State of Health	Age at Death	Cause of Death
Father							
Mother							
Siblings	No. of Living _____ No. of Deceased _____						
Children	No. of Living _____ No. of Deceased _____						
B. Owner/Payor							
Father							
Mother							
Siblings	No. of Living _____ No. of Deceased _____						
Children	No. of Living _____ No. of Deceased _____						
2. Family Physician (if any)	Name			Address			

If you answered yes to any of the following questions, please provide full details in space provided below.	Proposed Assured		Owner/Payor	
	Yes	No	Yes	No
3. Have any of your parents or siblings, died or suffered from heart disease, stroke, high blood pressure, diabetes, kidney disease, or cancer?	☐	☐	☐	☐
4. Are you an incumbent elected official, local or national, or seeking, planning, contemplating to hold any elective position? If yes, please specify position.	☐	☐	☐	☐
5. Have you lost/gained weight during the past 12 months? How many pounds / kilos? Why?	☐	☐	☐	☐
6. a. Have you, for physical reason, ever been refused or discharged from employment, active military or naval service?	☐	☐	☐	☐
b. Have you applied for or received disability benefits or pension from any source?	☐	☐	☐	☐
7. Have you used alcoholic beverages in excess, taken habit forming drugs or sought advice or treatment for alcoholism, drugs or other forms of addiction?	☐	☐	☐	☐
8. Are you engaged in any hazardous avocation like car/motorcycle racing or scuba diving? How often?	☐	☐	☐	☐

Please give details to the YES answers you indicated on item nos. 3 to 8 above.

PART IV. HEALTH DECLARATION

If you answered yes to any of the following questions, please provide full details in space provided below.	Proposed Assured		Owner/Payor	
	Yes	No	Yes	No
9. Has the Proposed Assured/Payor: a. Ever had medical consultation or treatment by any Physician or other Medical Specialist for any disease pertaining to:				
1) brain or nervous system?	☐	☐	☐	☐
2) lungs or respiratory system?	☐	☐	☐	☐
3) kidney or genito-urinary system?	☐	☐	☐	☐
4) hypertension, heart or circulatory system?	☐	☐	☐	☐
5) liver or other abdominal organs?	☐	☐	☐	☐
6) sexually transmitted diseases, AIDS, cancer, diabetes, goiter & blood or lymphatic related diseases?	☐	☐	☐	☐
b. Ever had consultation, hospitalization, surgical operation, accident, injury, medical advice or examination other than those mentioned above?	☐	☐	☐	☐
c. Ever had any physical defect or deformity, mental impairment, impaired hearing or eyesight, tumor, lump or abnormal growth in any part of your body?	☐	☐	☐	☐
d. Ever had X-ray, Electrocardiogram (ECG), biopsy, blood analysis and other diagnostic or pathologic tests? If yes, for what reasons?	☐	☐	☐	☐
e. For the Child Applicant (6 months to 5 years old): Was the child born prematurely?	☐	☐	☐	☐
Does the child have any physical/congenital defect?	☐	☐	☐	☐
10. FOR WOMEN ONLY (single or married) a. Date of last menstrual period?				
b. Are your menstruation periods irregular?	☐	☐	☐	☐
c. Have you ever had tumor or disease of the breast, uterus, or ovary?	☐	☐	☐	☐
d. Are you now pregnant? How many months? _____If pregnant, please check alternative below:	☐	☐	☐	☐
☐Pregnancy lien to be attached to Benefit Certificate ☐Pay extra contribution of P5.00 per P1,000 of amount of insurance for one year.				
11. Height (ft. and in.)				
12. Weight (lbs)				

Please give details to the YES answers you indicated on item nos. 9 to 10 above.

Question No.	Diagnosis	Date of Consultation / Confinement	Treatment/Medication	Physician/s' Name and Address

DECLARATION AND AGREEMENT

I declare and agree:

a. That I have read this page of my application in its entirety and I fully understand its contents, and that each and every statement and answer made by me is true, to the best of my knowledge, belief and based on official documents.

b. That if required by KCFAPI, I will promptly submit to one or more medical examinations in connection with this application.

c. That I waive, unless prohibited by law, on behalf of myself and my beneficiary or beneficiaries, the privileges and benefits of any and all laws in the Philippines, which are now in force or which may in the future be enacted disqualifying any physician, nurse or other attendant from testifying any action, suit or proceedings as to any facts learned in the course of their professional employment. I consent, unless prohibited by law, that any physician, nurse or other attendant may testify as to such facts in any action, suit or proceedings as fully and freely as though such law had not been enacted.

d. That failure to act or delay in action, or failure to give or a delay in giving to me notice of any action upon this application, shall not create any liability on the part of KCFAPI.

Signed at_____this _____ day of _____, 20 _____.

_____
Signature of Proposed Assured over Printed Name

If Proposed Assured is below 18 years old, owner/payor must also sign below:

_____
Signature of Owner/Payor over Printed Name

FRATERNAL COUNSELOR'S (FC's) CONFIDENTIAL REPORT ON APPLICANT

1. a. How long have you known the Proposed Assured/Payor?

_____

b. Are you related to the Proposed Assured/Payor? If yes, please state relationship.

_____

2. a. What is the Proposed Assured/Payor's approximate net worth?

_____

b. His/Her gross yearly income?

_____

3. His/her other sources of income, if any?

_____

4. Do you know any information concerning the Applicant's habits, finances, marital status, involvement in politics, legal cases, etc? If so, please give details.

_____

_____

5. Additional remarks:

_____

_____

I certify that I have read and explained each question in this page to him/her and that his/her answers are recorded exactly as given, that my Confidential Report has been made to the best of my knowledge and belief and that I am not withholding any information that may be adverse to this application, in compliance with the Fraternal Counselor's Manual and existing rules of the Association.

_____ _____
Signature of FC over Printed Name FC Code No.

_____
Date Signed

REPLACEMENT NOTIFICATION FORM

Insured:		Date of Birth	
Address:		Place of Birth	
Telephone / Mobile No(s)		E-mail Address	
Name of Applicant if other than Assured			
Existing Benefit Certificate(s)/Policy(ies) to be Replaced			
Company Name (as it appears on the BC/policy)			
Insured's Name (as it appears on the BC/policy)			
Certificate/Policy No(s)			

I certify that I understand the nature of this change and hereby affix my signature below.

_____ _____
Signature of Proposed Assured Over Printed Name Date Signed

Note: KCFAPI will furnish a copy of this form to the insurer(s) above.

Amount of Deposit (If Any)	Currency	TR/OR No.	Date
	☐ Peso ☐ US Dollar		

Revised: 03/24/15