KofC Family ... Our Concern

Knights of Columbus Fraternal Association of the Philippines, Inc.

BC RETENTION AND SERVICES DEPARTMENT

KCFAPI Center, Gen Luna corner Sta. Potenciana Sts., Intramuros, Manila 1002 ▪ PO Box 510 CPO Manila
Tel. No.: (02) 8527-2223 to 27 | (02) 8527-2249 to 55 ▪ Text: 0917-825KOFC (or 0917-8255632)
Website: www.kofc.org.ph ▪ E-mail Address: bcservices@kofc.org.ph

APPLICATION FOR REINSTATEMENT OF BENEFIT CERTIFICATE (BC)

Assured's Name (Please print): _____ **BC No:** _____
Payor's Name (If Assured is minor): _____ Date of Birth: _____
Residence: _____ Council No.: _____
Telephone: _____ Mobile Phone: _____ E-mail: _____

QUESTIONS	YES	NO
1. *For KC members only*: Are you at present a member in good standing?	☐	☐
1.a. Are you affiliated to any other fraternity, association or organization aside from the Knights of Columbus? If yes, kindly indicate: _____	☐	☐
2. *For immediate family of KC members:*		
2.a. Is your husband, father, son or grandfather, a member of the Knights of Columbus in good standing?	☐	☐
2.b. Is your husband, father, son or grandfather, who is a current member of the Knights of Columbus, belongs or is affiliated to any other fraternity, association or organization? If yes, kindly indicate: _____	☐	☐
3. Are you at present in good health? If no, please give details below.	☐	☐
4. Since the date of your last application for insurance, reinstatement, or modification of this benefit certificate with KCFAPI:		
a. Have you had any illness, disease, injury, or physical deformities?		
b. Have you consulted, been treated or operated by any physician /specialist?	☐	☐
c. Have you been confined in a clinic, hospital, or institution?	☐	☐
d. Has there been any death or illness among the immediate members of your family?	☐	☐
e. Has there been any change in your occupation? If so, please furnish us exact duties.	☐	☐
f. Do you within the next 12 months intend to make any aerial flights other than as passenger on scheduled commercial airlines?	☐	☐
g. Have lost weight during the past 12 months? How many pounds and why?	☐	☐
4. Have you received any disability benefit or compensation from any source?	☐	☐
5. Have you applied for a new insurance, change of plan or reinstatement of insurance, which was declined, postponed, withdrawn, or modified in kind, amount or rate?	☐	☐
6. For female applications only: Are you now pregnant? If yes, how many months? When was your last menstrual period? (If pregnant, a pregnancy lien shall be attached to your Certificate.)	☐	☐
DETAILS (Dates, symptoms, duration, treatment, results, name of physician and/ or hospital and address):		

I FURTHER AGREE THAT:

1. The payment herein made shall not be binding until and unless this application is actually approved by the Association during the lifetime and good health of Assured; and prior to this approval, the Association shall not be liable for any loss which occurs before the requirements for application are fully fulfilled.
2. The contestability and suicide clause (two-year period) shall start again from the effectivity of this reinstatement.
3. I hereby declare that all the foregoing answers and statements are complete, true and correct, to the best of my knowledge, belief and based on official documents; and that if there be any fraud and misrepresentation in the above statement material to risk, KCFAPI, upon discovery within two (2) years from Effectivity Date of Reinstatement of the Benefit Certificate (BC) shall have the right to declare such BC as null and void.
4. I shall communicate to KC Fraternal any change on the above declarations up to the time that I receive the approval of reinstatement.
5. If the present Benefit Certificate is replaced by a re-dated Benefit Certificate, I shall surrender the present Certificate and consent to its cancellation and do forever release and discharge the Association from any or all claims, demands and liabilities whatsoever under the present Certificate.

Signed at _____ this _____ day of _____, _____.

_____
Signature of Assured Over Printed Name

_____
Signature of Irrevocable Beneficiary Over Printed Name
(Please use reverse side for other irrevocable beneficiaries)

_____
Fraternal Counselor's Signature Over Printed Name
(Please indicate FC Code)

_____
Payor's Signature Over Printed Name
(If Assured is Minor)

Please choose your desired method (Please check the appropriate box):

☐ **Pure Reinstatement/Back Premium Method**
Remit overdue and current insurance contributions with interest; full or partial payment of BC loan; and medical fee, if applicable.

☐ **Re-dating Method**
The issue date shall be amended. Remit difference in contributions with interest; full or partial payment of loan; reissue fee; and medical fee, if applicable.
Surrender BC. *(applicable only to certain plans and can be availed only once)*

Amount of Deposit/Payment: _____
TR/OR No.: _____ Date: _____

FOR HOME OFFICE USE ONLY: