

LOAN APPLICATION FORM

TYPE OF LOANS

- | | | |
|--------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> REGULAR LOAN | <input type="checkbox"/> PAMASKO LOAN | <input type="checkbox"/> FRINGE BENEFIT LOAN |
| <input type="checkbox"/> MULTIPURPOSE LOAN | <input type="checkbox"/> SPECIAL LOAN | <input type="checkbox"/> 13 th Month <input type="checkbox"/> 14 th Month |
| <input type="checkbox"/> EDUCATIONAL LOAN | <input type="checkbox"/> VEHICLE LOAN | <input type="checkbox"/> Mid-Year <input type="checkbox"/> Longevity |
| <input type="checkbox"/> EMERGENCY LOAN | <input type="checkbox"/> PANGKABUHAYAN LOAN | |
| <input type="checkbox"/> VACATION LOAN | <input type="checkbox"/> OTHERS SPECIFY _____ | |

<input type="checkbox"/> FOR PICK UP	PLEASE CHECK:
<input type="checkbox"/> DEPOSIT TO	
BANK NAME: _____	
ACCOUNT NUMBER: _____	

I HEREBY APPLY FOR A LOAN BASED ON THE AMOUNT AND PURPOSE SPECIFIED HEREIN. I FURTHER CERTIFY THAT THE STATEMENT AND DATA INDICATED HERewith ARE TRUE AND CORRECT AND SUBMITTED FOR THE PURPOSE OF OBTAINING A CREDIT.

LOAN AMOUNT	NUMBER OF MONTHS PAYABLE	LOAN DATE
EMPLOYEE ID NUMBER	NAME OF THE BORROWER	SIGNATURE
HOME ADDRESS	DATE OF BIRTH	MOBILE NUMBER
LOAN PURPOSE	EMAIL ADDRESS	MONTHLY SALARY
		TAX ID NUMBER

L O A N N O T E

I/We the undersigned, bind myself/ourselves jointly and severally to pay TELECOMMUNICATION EMPLOYEES MULTI-PURPOSE COOPERATIVE the sum of _____ with the interest computed at the rate of _____ percent per annum, interests deductible over a period of _____ months with the principal payment of P _____ per semi-monthly installments, the first payment to be made on _____ and a like amount every payday thereafter until the full amount has been paid.

In case of any default in payments of semi-monthly installments, the entire balance of the notes shall become immediately due and demandable without prior notice to the maker/co-maker, at the option of the holder. Each party to this note whether as maker, co-maker, endorser or guarantor, severally waives presentment of payment for formal demand, protest and notice of protest and dishonor of the same.

It is further agreed that in case payment shall not be made at maturity, I/we shall pay the cost of collection and attorney's fees in an amount equal to twenty percent of the principal and interest due on this note, but in no events shall such charge be less than FIVE HUNDRED PESOS.

In case of judicial execution of this obligation or any part of it, the debtor waives all his rights under the provisions of Rule 3, Section 13 and Rule 39, Section 12 of the Rules of Court.

AUTHORITY (FOR PLDT EMPLOYEES ONLY)

I/we hereby authorize the Philippine Long Distance Telephone Co. to deduct the Proceeds of our Terminal Pay any amount due the Telecommunication Employees Multi-Purpose Coop., and remit same to the Treasurer.

PLEDGE OF DEPOSITS

I/We, the undersigned hereby pledge all deposits and payments on deposits which I/ we now have or hereafter may have in this Cooperative as security for the above loan. This pledge is given to secure the payment of the above-described loan and interest, fines, cost or expenses that may accrue thereon, and I/we hereby authorize the Cooperative to apply any or all such deposits and payments on deposits to the payment of said loan and interest, fines, cost or expenses.

NAME OF CO MAKERS	SIGNATURE	EMPLOYEE NUMBER	MOBILE NUMBER	HOME ADDRESS

LOAN EVALUATION	REMARKS	REMARKS	RECOMMENDATIONS
_____ LOAN OFFICER		_____ GENERAL MANAGER	

CREDIT EVALUATION	CREDIT COMMITTEE REMARKS
_____ CHAIRMAN	_____ VICE CHAIRMAN
_____ SECRETARY	

Notice No. 1: This will be sent to all members of the cooperative as a General information.

NOTICE TO THE MEMBERS

Dear Valued Members:

This is to notify you that pursuant to Republic Act (R.A) No. 9510 and its Implementing Rules and Regulations (IRR), creating the Credit Information Corporation (CIC), we are mandated to submit your basic credit data (as defined in R.A. No. 9510 and its IRR), as well as any regular updates or corrections thereof, to the CIC for the consolidation and disclosure as may be authorized by the CIC. Consequently, your basic credit data may thus be shared with other lenders authorized by the CIC, and other credit reporting agencies duly accredited by the CIC, for the purpose of establishing your creditworthiness.

For more information, please contact office or visit us, or call us at 032-253-2001/255-0100.

Notice No. 2: To be included in the loan application forms of the cooperative.

MEMBER'S AUTHORIZATION AND CONSENT

I hereby acknowledge and authorize **Telecommunication Employees Multi-Purpose Cooperative** to regularly submit, share, disclose my personal and credit data defined under RA 9510, the Credit Information Sharing Act (CISA) and its Implementing Rules and Regulations, and not in violation to RA10173 of 2012, the Data Privacy Act, to the following:

1. Credit Information Corporation (CIC)
2. Philippine Cooperative Central Fund Federation (PCF) for its Cooperative Credit Information Sharing Program called 'iMCOOP", and for coop analytics

I further consent and authorize **Telecommunication Employees Multi-Purpose Cooperative** the pulling and disclosure of my credit data and report from the CIC by its authorized accessing entities to establish my creditworthiness as part of credit investigation process.

I further authorize the use of my credit data and report by CIBI Information Inc., a CIC accredited special accessing entity for Coop Analytics and Credit Bureau purposes.

(MEMBER SIGNATURE OVER PRINTED NAME)



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 358 Sen. Gil J. Puyat Ave., Makati City
 1209 Philippines
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 TIN 203-028-895-000

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INDIVIDUAL APPLICATION AND HEALTH STATEMENT FORM

In the Philippines, group insurance products and medical benefits are provided by Generali Life Assurance Philippines, Inc. ("GLAPI"), a wholly owned subsidiary of the Generali Group.

General Instruction: Kindly fill out all the information needed, when applicable, using Black or Blue ink only.

Last Name		First Name		Middle Name		Membership as a <input type="checkbox"/> Principal <input type="checkbox"/> Dependent	
						If a Dependent, indicate the name of Principal: _____	
Residence Address				(Street No.)		(Brgy.)	
(City/Municipality)		(Province)		(Country)		(Zip Code)	
Contact Details: Home		Office		Cell Phone		Fax	
Date of Birth (DD/MM/YYYY)		Place of Birth		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
Nationality		Citizenship		Occupation			
Source of Fund/Wealth				SSS/GSIS/TIN/Phil I.D. : Others (Please specify) :			
Name of Employer				Nature of Business			
Business Address				Email Address			
Occupation:				Date Employed (DD/MM/YYYY):			
<i>This portion is applicable for Credit Life coverage only</i>							
Loan Amount				Loan Term			

NAME OF BENEFICIARY (First Name, M.I., Last Name)	DATE OF BIRTH	CITIZENSHIP	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____

	Y	N	Details of "yes" answers (Use separate sheet if needed)
1. Any weight change (lost/ gained) of more than 5 lbs. during the last 5 months? If so, by how many pounds and what was the reason for the loss/ gain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Have you ever suffered from or sought medical treatment for:	<input type="checkbox"/>	<input type="checkbox"/>	_____
a. epilepsy, fainting or any disorder of mental or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. asthma, bronchitis or any lung problem?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. chest pain, stroke or any heart disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. indigestion, ulcer, chronic or recurrent diarrhea, or any other disorder of the digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. diabetes or any disorder of the kidney, liver or urinary system?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. rheumatic fever, arthritis, gout or any joint or bone disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. cancer, tumor, enlarged gland or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. unexplained recurrent or persistent fever, weight loss or any skin disorder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. any sexually transmitted disease (such as syphilis or gonorrhea) or viral disease (e.g. hepatitis B or AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. any other illness, injury, not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	_____

"DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph"



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GENERALI

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3. Have you ever been diagnosed as suffering from hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Have you ever been prescribed drugs for any conditions in 1, 2 or 3?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Have you ever been confined in nursing homes, sanitariums, hospitals for illness, surgical operations, or invasive procedures different from appendectomy, tonsillectomy, adenoidectomy, hemorrhoidectomy, herniectomy, cholecystectomy, child delivery, made within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Have you ever undergone laboratory test or other diagnostic examinations which revealed abnormal results?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Any hospital confinement or surgical procedure being contemplated due to 6?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Have you ever received treatment with any blood products or undergone blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Any other disease or complaint not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Except as prescribed by a physician, have you ever used shabu, cocaine, heroin, marijuana or other narcotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Do you smoke or have you ever smoked more than 10 cigarettes per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Do you take or have you ever taken more than six units of alcohol per day (1 unit = ½ pint beer/ lager, 1 standard glass of wine, 1 pub measure of spirit)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Have you ever been advised by a physician to stop smoking or drinking alcohol or to drink in moderation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Are you currently taking medications, or are you under medical care of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. For females: Are you pregnant? Any complications with pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Do you have any relative who holds or has held a senior position in government, a political party, the military, or any tribunal or government- owned corporation?	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Do you have any other application for a reinstatement of life insurance pending? If yes, give details.	<input type="checkbox"/>	<input type="checkbox"/>	_____
With GLAPI	P	<input type="checkbox"/>	_____
With other companies	P	<input type="checkbox"/>	_____

I, the proposed life insured individual, declare under the penalty of perjury that to the best of my knowledge and belief the above answers and statements are true, complete and correctly recorded; and agree that, this application, if approved, with the answers given in any other declaration which may be required by Generali Life Assurance Philippines, Inc. (GLAPI) and which relates to the insurability of the proposed life insured individual or to change of this policy coverage, shall be the basis for delivery, change or reinstatement of insurance coverage.

By signing below, I agree that:

- I understand that the GLAPI is a member of Generali Group and it may have obligations to meet the requirements of both local and foreign regulatory authorities (including local and foreign tax authorities such as the U.S. Internal Revenue Service) as well as other legal obligations relating to information sharing and tax reporting from time to time ("regulatory and legal requirements").
- All material facts, being facts which might influence the assessment of this Application, have been truthfully, completely and correctly disclosed in this Application and/or any other declaration which may be required by GLAPI, it being understood that my failure to make such disclosure renders the contract void.
- I consent to the collection, processing, use and storage of information provided to GLAPI and I will provide the information they will request from time to time and allow them to share/report such information with their local and foreign authorities (including local and foreign tax authorities) to meet said regulatory and legal requirement as well as accredited third party service provider for the execution of the Policy Contract and its supplementary benefits. All medical information given will be uploaded to a medical information database accessible to all insurance companies for the purpose of enhancing risk assessment and preventing fraud.
- I will notify GLAPI as soon as possible of any change in the information that I have provided to them, including any circumstances such as a change in my residence, address, telephone number and citizenship.
- I hereby waive any rights I may have that would prevent GLAPI from meeting reporting requirement mentioned above.
- GLAPI reserves the right to deny claims on the basis of gross fraud or valid grounds recognized under the laws and settled jurisprudence in case of death in any year.
- During the effectivity of the of the contract policy, the customer/client agrees to the following:
 - measures to restrict the services available or prohibit any further transaction on the contract/policy until full/proper CDD measures have been successfully conducted and;
 - in case the foregoing is unsuccessful, terminate business relationship. The exercise of the Company of this measure shall only entitle customer/client to receive the unused portion of premiums or withdrawal value, if any, whichever is applicable.

SIGNED AT _____ ON _____

SIGNATURE OVER PRINTED NAME
OF WITNESS

SIGNATURE OVER PRINTED NAME
OF PROPOSED INSURED INDIVIDUAL

"DISCLOSURE: In accordance with the Insurance Commission's Circular Letter No. 2016-54 your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph"