HEALTH VANTAGE REGISTRATION FORM

This portion to be completed by PhilCare	
Agreement Number	

PLEASE PROVIDE COMPLETE INFORMATION.

LAST NAME

FIRST NAME

MIDDLE NAME

SUFFIX (Jr., III)

PERMANENT ADDRESS

OFFICE ADDRESS

RESIDENCE TEL NO. 63

MOBILE NO. 639

BUSINESS TEL. NO 63

EMAIL ADDRESS

AGE	**CIVIL STATUS**
BIRTHDATE (MM/DD/YYYY)	**SEX**
PLACE OF BIRTH	**HEIGHT (FT)** / **WEIGHT (LBS)**

PAYOR'S DETAILS

AGE	**SEX**
BIRTHDATE (MM/DD/YYYY)	**RELATIONSHIP TO ENROLLEE**
JOB TITLE	**CIVIL STATUS**

ESTIMATED TOTAL MONTHLY HOUSEHOLD INCOME

- ☐ 10,000 or below
- ☐ 10,001 - 20,000
- ☐ 20,001 - 50,000
- ☐ 50,001 - 100,000
- ☐ 100,001 and up

CHOOSE ONE (1) PLAN ONLY.

HEALTH VANTAGE KIDS

	Plan 40	Plan 60	Plan 80
Total Benefit Limit	Php 40,000	Php 60,000	Php 80,000
Room Type	Ward	Semi-Private	Regular Private
Membership Fee (VAT Inclusive)	Php3,850.00	Php9,050.00	Php13,950.00
Desired plan			

HEALTH VANTAGE ADULTS

	Plan 40	Plan 60	Plan 80
Total Benefit Limit	Php40,000	Php 60,000	Php 80,000
Room Type	Ward	Semi-Private	Regular Private
Membership Fee (VAT Inclusive)	Php3,750.00	Php5,950.00	Php9,950.00
Desired plan			

Delivery Fee (w/n Manila P65, Luzon P75, Visayas P95, Mindanao P110
Note: For Health Vantage enrollees below 18 years old are not eligible for AD&D and Term Life

By signing below, I certify that the information given by me is true and correct and that any material misrepresentation or falsity therein shall be construed as act to defraud PhilHealth Care Inc. (PhilCare), and a sufficient ground for legal action and the rejection of my application and membership. I hereby authorize PhilCare to inquire about and investigate all declared information from whatever sources PhilCare may consider appropriate.

I agree that receipt of the corresponding membership fees by PhilCare does not constitute acceptance of my application until the corresponding application has been approved and my Health Vantage card has been issued to me. Effectivity of the card starts 7 days from notice of confirmation of the acceptance of my application. Any incident, illness or condition that occurs prior to Effectivity Date will not be covered.

Approval of this application is subject to the receipt of full payment, application form, and photocopy of valid ID with signature. Further, I agree that the application form and related documents submitted to PhilCare shall not be returned to me for whatever reason. In case of disapproval of my application, the membership paid and remitted will be refunded to me by PhilCare. PhilCare is under no obligation to provide me with the reason for disapproval of my application.

I have read and understood completely the Terms and Conditions governing the issuance and use Health Vantage card.

I also reconfirm my agreement to the Declaration stated above.

Signature over Printed Name of Principal / Guardian for minor enrollee

DATE:

WHERE DO YOU WANT THE AGREEMENT AND MEMBERSHIP PACKAGE TO BE SENT?

☐ PERMANENT ADDRESS ☐ OFFICE ADDRESS

Document requirements checklist:

(1) Application form (2) Photocopy of valid ID with signature (3) Photocopy of proof of payment

(This portion is to be accomplished by agents) **APPLICATION NO.**

AGREEMENT NO.	APPLICANT'S NAME	☐ HEALTH VANTAGE KIDS	☐ HEALTH VANTAGE ADULTS	
		MEMBERSHIP FEE	P	OTHERS (PLEASE SPECIFY)
EFFECTIVE DATE	AGENT'S NAME/CODE	PHILCARE PHILHEALTH RIDER	P	
		PROCESSING FEE	P	
	RECEIPT NUMBER	VALUE ADDED TAX	P	
		TOTAL	P	