Nabunturan Integrated Cooperative
Corner Echavez-Fuentes Sts., Purok 10, Poblacion, Nabunturan, Compostela Valley Province
Email Address: coop_nico@yahoo.com

[redacted]

Application#_____

Nabunturan Integrated Cooperative Health Savers Plan (NICO-HSP)

NOTE: Please fill-up the required fields clearly.

PLANHOLDER/PRINCIPAL DEPOSITOR'S NAME: _____
DEPOSITOR'S BIRTHDATE: _____
DEPOSITOR'S ID. NO.: _____

PRINCIPAL DEPOSITOR/Planholder: _____ _____ _____
FAMILY NAME FIRST NAME M.I.

BIRTHDATE:_____ **AGE:**_____ **CIVIL STATUS:**_____ **GENDER:**_____

ADDRESS: _____

**Co-Assured Dependents/Immediate family members:*

SPOUSE *(if Planholder is Married)* * _____ _____ _____
FAMILY NAME FIRST NAME M.I.

BIRTHDATE:_____ **AGE:**_____ **CIVIL STATUS:**_____ **GENDER:**_____

ADDRESS: _____

One (1) ADDITIONAL Co-ASSURED *(Child, if Planholder is married; Parent/Sibling, if Planholder is single)**

Name	Birthdate (mm/dd/yyyy)	Age	Relationship
1.	/ /		

Eligibility Requirements:

1. Planholder must be member-depositor of the cooperative who is 18 to 69 years old. Exit age is on the 70th birthday.
2. Dependents of the member must be the immediate family members:
   - *for married member: spouse 18 to 69 years old and children from 4 to 22 years provided that single and still living with parents;*
   - *for single member: parents and single siblings not more than 69 years old;*
   - *for single parents: children from 4 to 22 years old; & parents up to 69 years old who are able to do the normal daily activities of livelihood;*
3. Any co-assured dependent(s) that was declared already cannot be declared again by another principal borrower.
4. The coverage of the Co-assured Dependents will cease its effect if that person becomes a principal depositor.
5. Coverage is one (1) year.
6. Non-medical, provided at the effectivity of insurance they are in good health, able to do their usual daily activities and not afflicted with life threatening diseases or terminal illnesses.
7. Must fill-up the application for insurance.

1. Features	Confinement per Day		One (1) Additional Rider	
Maximum Ten (10) Days per Policy Year	Principal	Spouse	Child *(if principal is married)*	Parent / Sibling *(if principal is single)*
	Php500	Php500	Php250	
2. Age Eligibility	18-69 years old	18-69 years old	4-22 years old	18-69 years old
3. Annual Premium	Php 500			

I hereby certify that I am in good health and able to perform the usual duties of my livelihood. I further certify that me and/spouse and the persons listed for insurance coverage are of good health and are free from any life-threatening sickness or disease. That this application shall form part of the policy/certificate and shall also be the basis for the issuance of my CERTIFICATE of membership.

Cagayan de Oro City, Philippines, this _____day of _____ 20____.

_____
Signature over Printed Name of Planholder/Principal Depositor

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Application Number_____

CLIMBS LIFE AND GENERAL INSURANCE COOPERATIVE

CLIMBS Building, Upper Zone 5 National Highway Bulua, Cagayan de Oro City 9000, Philippines
Telephone / Fax Nos. (632) (88) 856 1355 Email: head_office@climbs.coop

CONFIRMATION OF COVERAGE

CLIMBS Life and General Insurance Cooperative certifies that it has insured the following person/s:

Complete Name of the Planholder/Principal Depositor: _____
Co-Assured Dependent/s:
1). *Complete Name of Spouse, if Planholder is married:* _____
2). *Complete Name of the Qualified Co-Assured:* _____

In accordance with the provision of Group Master Policy, the Company will pay to the Insured/ or his Dependents the face amount of the benefits as found in the Schedule of Benefits, promptly upon receipt of satisfactory proof of claims. This certificate will in no way void any of the provisions of Group Master Policy.

Health Savers Plan

_____
Signature over Printed Name of Planholder/Principal Depositor

Issue Date: _____
Name and Signature of Authorized officer: _____