



**PERSONAL ACCIDENT APPLICATION FORM – CORPORATE CLIENT**

*Client information as mandated under the Phil. Anti-Money Laundering Act (AMLA) R.A No.10365 as amended.  
Complete information is required before a policy is issued.*

Business/Company Name:		
Business/Company Address:	Contact No.:	
	E-mail Address:	
Nature of Business:	TIN:	
Date of Incorporation:	Place of Registration:	
List of Directors/Partners:	List of Principal Stockholders Owning at least 2% of capital stock (or attach the latest General Information Sheet):	
Beneficial Owners, if any:		
Name of Authorized Representative:	Position:	Contact No.:
Form completed by:	Position:	Date:
<b><i>Please attach Articles of Incorporation/Partnership and By-Laws</i></b>		



**UNDERWRITING DETAILS**

Amount of Insurance Requested: Php \_\_\_\_\_

**Coverage:**

**Basic Coverage – Accidental Death & Permanent Disablement**

**Additional Extensions Requested:**

- Murder & Assault
- Medical Expense Reimbursement
- Burial Expense
- Motorcycling Coverage
- Non-Scheduled Flight
- Daily Cash Assistance (due to Accident only)

**Other Information:**

Do you engage in hazardous sports or contemplate any special journey or hazardous undertaking?  Yes  No  
If yes, what are they? \_\_\_\_\_

Do you intend to travel by air?  Yes  No  
If yes, please state how frequently in a year? \_\_\_\_\_

To the best of your knowledge and belief, have you ever been treated or been told you have heart disease, epilepsy, sexually transmitted disease, diabetes, renal disease, injury to or disease of the spine or sacro-iliac joint, or mental or nervous disorder?  Yes  No  
If yes, please provide details? \_\_\_\_\_

To the best of your knowledge and belief, have you ever been disabled or suffered from any disease or received any medical or surgical treatment or advice during the past five years?  Yes  No  
If yes, please provide details? \_\_\_\_\_

Do you have any deformity, impairment of hearing or vision, or loss of hand, foot or vision?  Yes  No  
If yes, please provide details? \_\_\_\_\_

Have you ever held or currently holding an elective public office?  Yes  No  
If yes, please provide details? \_\_\_\_\_

**Loss History:**

Have you had any losses, claims or incidents during the last 5 years?  Yes  No  
If yes, please provide details? \_\_\_\_\_

Have you ever had any life, accident or sickness insurance declined, canceled or renewal refused?  Yes  No  
If yes, please provide details? \_\_\_\_\_

Do you have an existing agent with BPI/MS?  None  Yes Agent's Name: \_\_\_\_\_

*Note: This Application, if approved, shall form part of and shall be the sole basis in issuing the Personal Accident Insurance Policy. Any material fact disclosed or misrepresented at the time this Application is accomplished, shall exempt the Insurer from any liability caused or brought about by such undisclosed or misrepresented material fact.*



# BPI / MS Insurance Corporation

F-S&U-25  
Revision No. 02  
June 1, 2016

*"I hereby authorize BPI/MS to inquire about and investigate all the declared information from whatever sources BPI/MS may consider appropriate and use any contact details to communicate to me for whatever purpose (such as customer satisfaction surveys, etc.)."*

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

***"Financial product/s of BPI/MS is/ are not insured by the Philippine Deposit Insurance Corporation and is/are not guaranteed by the Bank of the Philippine Islands."***

## PAYMENT OPTIONS

Cash       BPI Debit Card       BPI Express Online       Credit Card

*Please refer to the Payment Facilities page for more details.*

\_\_\_\_\_  
**To be accomplished by BPI personnel**  
\_\_\_\_\_

## TRACKING FORM

Client's RM No.:
Referrer's name:
Referrer's Employee No.:
Referring Branch code:
Referring Branch name:
Dealer's name: