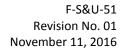


TRAVEL PERSONAL ACCIDENT APPLICATION FORM - INDIVIDUAL CLIENT

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.

Complete Name:				Sex:		
				☐ Male ☐ Female		
Citizenship:	Civil Status:		Date of Birth:	Place of Birth:		
	☐ Single	☐ Married				
	☐ Separated	☐ Widow				
Residence Address:		Telephone/Mobile/Fax No.:				
			Email Address:			
SSS, GSIS, Driver's License or Passport No. (For Driver's License and Passport, please indicate "Date of Expiry"):				TIN:		
Name of Business/Employer:			Occupation/Designation:			
Business/Employer Address:			Contact No.:			
			Fax No.:			
Nature of Business (If self-employed):						
If unemployed, please state source of funds:						
Name of Beneficiary/Relationship, if applicable:						
Address of Beneficiary:						
Please check your preferred mailing address: ☐ Residence Address ☐ Business Address						

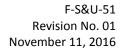




UNDERWRITING DETAILS

Type of Plan								
☐ DOMESTIC	□ NON-SCHENGEN (Asia, America & Other Non-European	SCHENGEN (European Union Member Countries)	☐ INDIVIDUAL ANNUAL					
☐ Php200,000	Countries)	(European Onion Member Countries)		VEL CARE of 90 days per trip)				
☐ Php500,000 ☐ Php1,000,000 ☐ Php1,500,000 ☐ Php2,000,000 ☐ Php3,000,000 ☐ Php4,000,000 ☐ Php5,000,000 ☐ Travel Period	☐ Gold - Php1,000,000 ☐ Diamond - Php2,000,000 ☐ Platinum - Php3,000,000	☐ Gold - Php1,000,000 ☐ Diamond - Php2,000,000 ☐ Platinum - Php3,000,000	☐ Gold - Ph					
		Return Date:						
Place of Travel From: To: Purpose of Travel								
OTHER INFORMATION								
Do you have any other life, a	□Yes	□No						
If yes, please provide details (Insurer/Amount)								
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?				□No				
If yes, please provide details								
To the best of your knowled from any disease or received past five years?	□Yes	□No						
If yes, please provide details	;							
Do you have any deformity, vision?	□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 Travel Personal Accident Insurance Policy. Any material fact concealed 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.





"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: