DATE RECEIVED

mm-dd-yy

Maxicare Healthcare Corporation

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PART I. EMPLOYEE INFORMATION

Employee Number	EMPLOYEE NAME *Last Name, First Name, M.I.*	Department/Branch

RESIDENTIAL ADDRESS *Number, Street, Village, Barangay, City*	Region	Residential/Cellphone Numbers:

Birthday *Month-Day-Year*	Age	Sex	Civil Status	# of Children	Office Numbers

PART II. DEPENDENTS INFORMATION

Full Names of Employee's Dependents *Arrange Name Chronologically Based on Age*	**Relation**	**Gender**	**Civil Status**	**Birthday M-D-Y**	**Age**	Philhealth Additional P1,500./person/year	
						Yes	**No**
1							
2							
3							
4							

**** Please print and write clearly. All information written above upon submission shall be considered true and final.***

PART III. ELIGIBILITY *(Direct Dependents)*

A. ELIGIBLE DEPENDENTS AND AGE REQUIREMENT

For Single Employees: Single and unemployed children from 15 days old to 21 years old OR Parents up to 75 years old

For Married Employees: Spouse up to 75 years old
Single and unemployed children from 15 days old to 21 years old

****Coverage for 21 years old minor dependents & 75 years adult dependents shall be extended up to 6 months upon their birth date.***

**** Marriage certificate & Birth certificate must be submitted together with the application form.***

i.e. Birthday January 1, 1986
Coverage will expire up to July 31, 2007

Eligible Dependents for enrollment are those falling under the *Direct Dependents* category, as enumerated above.

Enrollment of additional Dependents in the middle of the coverage year is not allowed except for the following cases:

- ✓ Newly born child shall be enrolled within 1 month after birth
- ✓ Spouse of newly married employees shall be enrolled within 1 month after date of marriage

The following are allowed to be cancelled in the middle of the coverage upon submission of supporting documents (i.e company ID, work visa abroad, etc):

- ✓ Dependent whose age is beyond the eligibility (e.g. Child's age at 21 years)
- ✓ Working dependent with own healthcare coverage
- ✓ Dependent who has left the country for good

PART V. CERTIFICATION/AUTHORIZATION

CERTIFICATION

I hereby certify that all information contained in this application form are true and complete to the best of my knowledge and belief, and that any misrepresentation as to material fact indicated herein shall be a cause for the cancellation/discontinuance of the HMO coverage.

______________________________ ____________________

SIGNATURE OF EMPLOYEE **DATE**