



**COOP LIFE GENERAL INSURANCE AND FINANCIAL SERVICE AGENCY (CLIFSA)**

CLIFSA Building, M.H. Del Pilar, Barangay 17, Cagayan de Oro City, Philippines  
Tele/Fax: (088) 8565644| Moblie: 0917 852 8609 | Email: clifsa\_cdo@yahoo.com



**Coop ER+ Application Form**

Application No. \_\_\_\_\_

Name of Coop/ Group \_\_\_\_\_

Principal  Spouse  Dependents

Last Name :		First Name :		Middle Name:	
Date of Birth (mm/dd/yyyy):	Age:	Place of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Civil Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Separated	
Present Occupation:	Citizenship:	Weight:	Height :	Religion :	
Residence Address:	Contact No:		Source of Income :		

Benefit Option ( pls. check one)  New  Renewal

	<input type="checkbox"/> Coverage 1	<input type="checkbox"/> Coverage 2
Daily Hospital Confinement up to 365 days	500	1,000
Emergency Room per year	5,000	10,000
Accident Death for Principal Member	50,000	100,000



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**CONFIRMATION OF COVERAGE**

This certifies that the person named below is insured with Coop Life General Insurance and Financial Services Agency for the amount stated hereunder for one (1) year from effective hereof. This certificate is governed by the terms and conditions of the master policy issued by Coop Life General Insurance and Financial Services Agency under the group to where the insured belong, and all claims for losses will be adjusted in accordance herewith.

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_  
Date

Accident Burial Benefit	5,000	10,000
Fire Cash Assistance per year	Max. 5,000	Max. 10,000
Annual Premium	Php. 1,420	Php. 2,900

Providers: CLIMBS Life & General Insurance - Accidental Death & Burial Benefits/Fire Cash Assistance  
Eastwest Healthcare Inc. - Daily Confinement & Emergency Room Coverage

**AUTHORIZATION TO PAY THE COOPER+ BENEFITS FOR EMERGENCY CASES**

I, the undersigned (hereinafter called the Insured), of legal age, and residing at the indicated address, owner of a Policy issued by Coop Life General Insurance and Financial Services Agency (herein called the insurer), do hereby authorize the insurer to pay the medical expenses due to the coverage option selected above that may be rendered by a designated Eastwest Healthcare Provider and CLIMBS Life and General Insurance Cooperative Provider.

I HEREBY CERTIFY:

- That I have not reached 66 years old; that the above answer is true and complete; and agree that this shall be the basis of my proposed coverage;
- that this application shall be form part of the Master Policy and will also the basis for the issuance of my Confirmation of Coverage

I agree that Coop Life General Insurance and Financial Services Agency shall not be liable for any claim on account of illness or death, the cause of which as known prior application of coverage but was withheld or concealed in the above statements.

I understand and that disqualification from coverage will only entitle me to refund of premium.

In as much as I cannot read/write, or understand language, before I affixed my thumb mark (duly witnessed) to this application it had been read and translated to me by the authorized representative.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

Left      Right

Witnessed and issued by:

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For Inquiries:

Please Call Tel Nos.: 09 8565644

Please remit to this:

Account number:316-0017820

Account Name: CLIFSA

**General Exclusions**

Self-inflicted injuries, including infections as a result of tattoos, piercing on any body part aside from the ears, whether self-inflicted or done by a third party - Conditions resulting from domestic violence - Conditions attributable to the member's own misconduct, including unauthorized use of prohibited/regulated drugs, alcoholic liquor intake, direct or indirect participation in the commission of a crime, violation of a law or ordinance, unnecessary exposure to imminent danger

Conditions resulting from engaging in any risky sport or hazardous activity

Conditions resulting from direct participation in any act of war and state of civil, military, or political unrest -Psychiatric and/or psychological illnesses and conditions -Experimental and/or investigational medical procedures and its complications

Conditions resulting from aesthetic/ cosmetic surgery or procedure of any kind

Conditions resulting from any combat-related activity or from participation in any activity while in military service - Neonatal illnesses resulting from complications of pregnancy and delivery of the newborn

Sexually transmitted infections (STIs) and HIV infection, AIDS, and their complications

Congenital, genetic, hereditary diseases, and their complications, except if congenital benefits are recovered as indicated in the schedule of Benefits

All screening tests

Neurodevelopmental disorders

All pregnancy and maternity-related conditions, except if maternity benefits are covered as indicated in the Schedule of Benefits. - Purchase or use of durable medical equipment such as but not limited to oxygen dispensing unit, except if rented

while confined at the hospital - Demyelinating diseases of the nervous system, Autoimmunoneurologic disorders, and Neurodegenerative diseases

- Injuries or illnesses attributable to third party liabilities, if Member refuses to execute a Deed of Subrogation and Reimbursement -Diseases that are declared epidemic or pandemic by the Department of Health, World Health Organization, or any recognized health authority (i.e. Avian flu, Meningococemia, etc.) - Conditions arising from complications of alternative medicine - Professional fees for medico-legal cases; Professional fees of assistant surgeons except when the service of an assistant surgeon is medically necessary, subject to the approval of the Healthcare Provider

For Claims Availment please contact CLIFSA at Tel. Nos.: (088)856-5644; 880 1564  
 Email: [clifsa\\_cdo@yahoo.com](mailto:clifsa_cdo@yahoo.com)  
 Website: [clifsa.com.ph](http://clifsa.com.ph)

**QUALIFIED EMERGENCY CONDITIONS**

--Bleeding that will not stop --Sudden onset head and/or spine injury --Breathing problems (difficulty of breathing, shortness of breath) --Severe or persistent vomiting --Sudden changes in mental status (such as unusual behavior, confusion, difficulty arousing) --Sudden injury due to motor vehicle accidents, burns, smoke inhalation, near drowning, a deep large wound etc. --Chest pains --

Sudden and severe pain anywhere in the body -Choking --Sudden dizziness, weakness, or change in vision --Coughing up or vomiting blood -Introduction in vitro, and/or direct bodily exposure to poisonous and/or toxic substances --Syncope (fainting) or loss of consciousness --Sudden and severe abdominal pain or pressure

**Required Documents for Reimbursement**

+Duly Accomplished Reimbursement Form  
 +All Original Official Receipts  
 +Statement of Account (Detailed and Summary)  
 +Medical Certificate

**Required Documents for HIB Reimbursement**

+Duly Accomplished Reimbursement Form  
 +Statement of Account  
 + Medical Certificate  
 +All Original Official Receipts