Republic of the Philippines
Department of Finance
**PHILIPPINE CROP INSURANCE CORPORATION**
Regional Office No. _____

**APPLICATION & HEALTH STATEMENT**
**AGRICULTURAL PRODUCERS PROTECTION PLAN (AP3)**

Name: _____Civil Status _____Sex _____
Address : _____Date of birth _____Age_____
Occupation/Livelihood: _____Place of birth_____
Beneficiaries/: Primary: _____ Relationship _____Age_____
Secondary_____ Relationship _____Age_____
Trustee (if beneficiary is a minor) _____Relationship _____Age_____
Desired Insurance Coverage:

| | | | |
|---|---|---|---|
| □ Plan 15T | □ Plan 40T | □ Plan 65T | □ Plan 90T |
| □ Plan 20T | □ Plan 45 T | □ Plan 70T | □ Plan 95T |
| □ Plan 25T | □ Plan 50T | □ Plan 75T | □ Plan 100T |
| □ Plan 30T | □ Plan 55T | □ Plan 80T | |
| □ Plan 35T | □ Plan 60T | □ Plan 85T | |

For minor applicant only: With my parental consent: _____
Signature over Printed Name of Parent

Are you a family member or a worker of a farmer who has a live agricultural/crop insurance coverage with PCIC? (If yes, please indicate the name of the farmer and your relationship) Yes _____No_____
Name of Farmer_ _____Address: _____Relationship _____

| | | Yes | No | If yes, give details of diagnosis, duration, names and addresses of Medical Institutions , name of attending physician and medication and treatment. |
|---|---|---|---|---|
| 1 | Have you suffered or sustained any illness or injury, consulted a physician or been hospitalized during the last five (5) years? | | | |
| 2 | Have you been treated for or told, you have heart disease, high blood pressure, diabetes, kidney disease, liver disease, urino-genital disease, lung disease, cancer, ulcer, or any other serious disorders? | | | |
| 3 | Have you ever had or been advised to have any surgical operations? | | | |
| 4 | Have you ever been declined or had a plan postponed or modified for any life or disability insurance? | | | |
| 5 | Have you ever been counseled or medically advised or treated with any infectious or sexually transmitted disease? | | | |

I hereby certify that the foregoing answers and statements are complete, true and correct, signed in person. If the application be approved, the insurance shall be deemed based upon the statements contained herein. I further agree that PCIC reserves the right to reject and/or void the insurance if found that there is fraud/ concealment/ misrepresentation on this statement material to the risk.
Signed at _____ on this _____ day of _____, 20____.

_____ _____
Name & Signature of Witness Signature of Applicant