SkyAid Online Application Form

Date of Application:

Control No.:

Personal Information

Last Name:

First Name:

Middle Name:

Birthday:

Place of Birth:

Sex:

Civil Status:

Name of Spouse | **Birthday**

List of Dependents | **Birthday**

1

2

3

Email Address:

Citizenship:

Home Address:

Zip Code:

Mobile No.:

Home Phone No.:

Employer/Business Name:

Business Address:

Name of Person To Notify in Case of Emergency:

Relationship:

Contact No.:

Membership Application

Type of Plan

◯ Individual ◯ Family

◯ Couple ◯ Corporate

Duration of Plan

☐ One Month ☐ Six Months

☐ One Year

Medical Information

Have you been hospitalized in the last six months? ◯ Yes ◯ No

Have you ever availed of any medical or surgical treatment? (if yes, please give details below) ◯ Yes ◯ No

Are you presently taking any medical or surgical treatment? (if yes, please give details below) ◯ Yes ◯ No

Do you take alcohol, cigarettes, tobacco, or any habit-forming drug? ◯ Yes ◯ No

Payment Information

Modes of Payment

◯ Annually ◯ Cash

◯ Semi-annual ◯ Check

◯ Quarterly ◯ Credit Card

◯ Monthly

Number | **Amount**

Bank / Credit Card Name | **Branch Location**

Signature of Applicant

I certify that the information contained in this application form is accurate and complete. I understand and agree that failure to fully complete the form, or misinterpretation or omission of facts, represents grounds for elimination from consideration or termination of membership if discovered at a later date.