DOJ-COOP Form No. 2a **CAN BE REPRODUCED**

DEPARTMENT OF JUSTICE
EMPLOYEES' MULTI-PURPOSE COOPERATIVE
DOJ Building, Padre Faura St., Ermita, Manila
☎(02) 7617-7068 * 0927-6144820 * 0917-1378030
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APPLICATION FORM – GENERALI HEALTH CARD

Premium Payment Options:

☐ **MONTHLY** (PAYROLL DEDUCTION) ☐ **SEMI-ANNUAL** (MY & YE BONUS) ☐ **ANNUAL** (**MY / YE**)

Name of Member: _____ **PLAN** _____
Date of Birth /Age: _____
Gender / Civil Status: _____
Contact Number: _____
Email Address : _____
Beneficiary _____

OPTIONAL: ADDITIONAL ENROLLEE (INDIVIDUAL PAYMENT)

Name of Dependent (to be enrolled): _____ **PLAN** _____
Date of Birth /Age: _____
Relationship of Dependent to Principal: _____
Gender / Civil Status: _____
Contact Number: _____

Name of Dependent (to be enrolled) _____ **PLAN** _____
Date of Birth: _____
Relationship of Dependent to Principal:_____
Gender / Civil Status: _____
Contact Number: _____

NOTE: 1. SEE PREMIUM RATES AT THE BACK (PAGE 2) ☞
2. Please use additional sheet if necessary.

PROMISSORY NOTE

I, _____ hereby promise to pay the **Department of Justice Employees' Multi-Purpose Cooperative (DOJ-COOP)** directly, or through its Treasurer, or through Payroll Deduction, the amount of _____ (P_____), payable in _____ installments of _____ (P_____) as my **premium fee for my health maintenance insurance for one (1) year coverage**. **(PRE-TERMINATION OF PREMIUM IS NOT ALLOWED)**

I hereby agree that, in case of default in the payment of any installment, or in case of my disability, retirement, resignation, absence without official leave, and/or separation from the service, the entire unpaid balance of this health card, shall immediately become due and payable without need of any formal demand. I hereby agree to waive presentation of payment, demand, protest and notice of protest and dishonor of the same.

In case of the above mentioned cases, I hereby assign in favor of DOJ-COOP, without further notice, so much of my capital deposit, including earned dividends, with DOJ-COOP and all monies and monetary benefits due, or to be due, from my present office, that would be sufficient to pay off the entire outstanding balance of this health card. I, therefore, authorize the Department of Justice to deduct the necessary amounts from all monies due me and to remit the same directly to DOJ-COOP, thru its duly authorized representative.

_____	_____	_____
Date	**Applicant's Name and Signature**	**Official Station**

ELIGIBILITY:

PRINCIPAL (Age 18 – 65 years old)				
PLAN	MAXIMUM BENEFIT LIMIT	ANNUAL PREMIUM	SEMI-ANNUAL PREMIUM	MONTHLY PREMIUM
WARD	P 70,000.00	P 11,329	P 5,719	P 962
SEMI PRIVATE	100,000.00	15,014	7,580	1,275
PRIVATE	150,000.00	19,749	9,970	1,678
LARGE PRIVATE	200,000.00	37,048	18,704	3,147

DEPENDENTS (Spouse / Children age 14 days old – 23 yo / Parent up to 70yo / Siblings 14 days old – 23yo)				
PLAN	MAXIMUM BENEFIT LIMIT	ANNUAL PREMIUM	SEMI-ANNUAL PREMIUM	MONTHLY PREMIUM
WARD	P 70,000.00	P 13,117	P 6,622	P 1,114
SEMI PRIVATE	100,000.00	17,772	8,372	1,510
PRIVATE	150,000.00	24,007	12,120	2,039
LARGE PRIVATE	200,000.00	42,766	21,590	3,633

OVERAGE PRINCIPAL (Age 66 years old – 70 years old)				
PLAN	MAXIMUM BENEFIT LIMIT	ANNUAL PREMIUM	SEMI-ANNUAL PREMIUM	MONTHLY PREMIUM
WARD	P 70,000.00	P 20,670	P 10,435	P 1,764
SEMI PRIVATE	100,000.00	28,042	14,157	2,382
PRIVATE	150,000.00	37,511	18,937	3,187
LARGE PRIVATE	200,000.00	72,107	36,404	6,128

OVERAGE DEPENDENT (Age 66 years old – 70 years old)				
PLAN	MAXIMUM BENEFIT LIMIT	ANNUAL PREMIUM	SEMI-ANNUAL PREMIUM	MONTHLY PREMIUM
WARD	P 70,000.00	P 24,907	P 12,575	P 2,116
SEMI PRIVATE	100,000.00	34,216	17,274	2,907
PRIVATE	150,000.00	46,686	23,570	3,966
LARGE PRIVATE	200,000.00	84,205	42,511	7,153

NOTES:

1. Program is subject to Maximum Benefit Limit per **Disability**.
2. Pre-Existing Conditions (PEC) are covered.
3. Members have direct access to all our accredited Hospitals and Clinics.
4. All benefits are on **TOP OF PHILHEALTH BENEFITS**.