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 – PACIFIC CROSS 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. **Contact number will be enrolled in KonsultaMD**
**3. 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:**

| For PRINCIPAL (Age 18 – 65 years old) | | | | |
|---|---|---|---|---|
| **PLAN** | **MAXIMUM BENEFIT LIMIT** | **ANNUAL PREMIUM** | **SEMI-ANNUAL PREMIUM** | **MONTHLY PREMIUM** |
| WARD | P 80,000.00 | P 9,820 | P 5,486 | P 858 |
| SEMI PRIVATE | 100,000.00 | 11,200 | 6,221 | 979 |
| PRIVATE | 150,000.00 | 15,970 | 8,810 | 1,397 |
| LARGE PRIVATE | 200,000.00 | 21,380 | 11,734 | 1,870 |

| For DEPENDENTS (Age 15 days old – 65 years old) | | | | |
|---|---|---|---|---|
| **PLAN** | **MAXIMUM BENEFIT LIMIT** | **ANNUAL PREMIUM** | **SEMI-ANNUAL PREMIUM** | **MONTHLY PREMIUM** |
| WARD | P 80,000.00 | P 10,684 | P 5,901 | P 1,020 |
| SEMI PRIVATE | 100,000.00 | 12,190 | 6,720 | 1,164 |
| PRIVATE | 150,000.00 | 17,485 | 9,576 | 1,680 |
| LARGE PRIVATE | 200,000.00 | 21,380 | 12,810 | 2,244 |

**NOTES:**

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