



## MEMBERSHIP APPLICATION Overseas Filipino Dependents Program



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 Website: [www.medicardphils.com](http://www.medicardphils.com)

**INSTRUCTION:** Please print or type answer to questions applicable to applicant and check the appropriate box where applicable.  
**Forward to P.I.C. Corporation, 4-13-8, Shimomura Bldg., 2F, Kotobashi, Sumida-ku, Tokyo 130-0022 Japan.**

**PERSONAL INFORMATION OF OFW**

FAMILY NAME	FIRST NAME	MIDDLE NAME	SEX	CIVIL STATUS
MAILING ADDRESS (PHILIPPINES/ NUMBER, STREET, BRGY., CITY, AREA CODE)			HOME TEL. NO.	CELLPHONE NO.
MAILING ADDRESS (ABROAD/ NUMBER, STREET, CITY, STATE, ZIP CODE)			HOME TEL. NO.	CELLPHONE NO.
DATE OF BIRTH (MM/DD/YY)	GSIS/SSS NUMBER		OCCUPATION	

**BENEFICIARY / DEPENDENT INFORMATION (To be enrolled in the Program)**

**I.**

FAMILY NAME	FIRST NAME	MIDDLE NAME	SEX	CIVIL STATUS
MAILING ADDRESS (PHILIPPINES/ NUMBER, STREET, BRGY., CITY, AREA CODE)			HOME TEL. NO.	CELLPHONE NO.
DATE OF BIRTH ( MM/DD/YR )	RELATION TO PAYOR / OFW	GSIS / SSS NUMBER		

**II.**

FAMILY NAME	FIRST NAME	MIDDLE NAME	SEX	CIVIL STATUS
MAILING ADDRESS (PHILIPPINES/ NUMBER, STREET, BRGY., CITY, AREA CODE)			HOME TEL. NO.	CELLPHONE NO.
DATE OF BIRTH ( MM/DD/YR )	RELATION TO PAYOR / OFW	GSIS / SSS NUMBER		

**III.**

FAMILY NAME	FIRST NAME	MIDDLE NAME	SEX	CIVIL STATUS
MAILING ADDRESS (PHILIPPINES/ NUMBER, STREET, BRGY., CITY, AREA CODE)			HOME TEL. NO.	CELLPHONE NO.
DATE OF BIRTH ( MM/DD/YR )	RELATION TO PAYOR / OFW	GSIS / SSS NUMBER		

**ROOM PLAN (CHOOSE 1)**

**OPTION I - (For PHILHEALTH / OWWA Members) – W/O DENTAL Services**

PLEASE CHECK	ROOM & BOARD	ANNUAL MEMBERSHIP FEE			DREADED DISEASE LIMIT
		3 mos. – 60 yrs. old	61 – 65 yrs. old	66 – 70 yrs. old	
	PLAN 750	P 8,027	P 11,891	P 19,618	P 50,000
	Small Private up to Plan 1500	10,306	15,209	25,015	60,000
	Large Private up to Plan 2500	13,350	19,775	32,625	75,000
	Small Suite up to Plan 3000	17,136	25,454	42,090	100,000
	Large Suite up to Plan 4000	20,440	30,410	50,350	150,000

**OPTION II - (For NON-PHILHEALTH / NON-OWWA Members) – W/O DENTAL Services**

PLEASE CHECK	ROOM & BOARD	ANNUAL MEMBERSHIP FEE			DREADED DISEASE LIMIT
		3 mos. – 60 yrs. old	61 – 65 yrs. old	66 – 70 yrs. old	
	PLAN 750	P 9,227	P 13,091	P 20,818	P 50,000
	Small Private up to Plan 1500	11,506	16,409	26,215	60,000
	Large Private up to Plan 2500	14,550	20,975	33,825	75,000
	Small Suite up to Plan 3000	18,336	26,654	43,290	100,000
	Large Suite up to Plan 4000	21,640	31,610	51,550	150,000

**\*Include Dental Care Services! If yes, please check.**

	<b>Plus P300.00/head additional annual fee</b>
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We hereby certify that the foregoing answers are true and complete and to the best of our knowledge. We understand and agree that whenever necessary in the administration of the Service Agreement, MEDICard physicians may discuss with any hospital, health care facility, physician and surgeon, or other health care professional medical information related in this application.

We apply for MEDICard program membership and agree that we shall abide by the provisions of the contract and MEDICard regulations. We understand that there is no coverage unless our application is approved and that MEDICard will not be liable for any medical bills between the time that we sign this application and the effective date of our coverage if our application is approved. Any money we may have sent will be returned if the application is rejected, except our processing fee.

Please fax to 03-3635-9444 your bank deposit or email to [fujita@pic-network.co.jp](mailto:fujita@pic-network.co.jp) immediate posting/reconciliation of your payments. Remittance of payments may be made through any bank in Japan for deposit to **MEDICARD PIC CORPORATION, Ordinary Account No. 0831401**, Bank of Tokyo-Mitsubishi, Kinshicho Branch, 4-11-1, Kotobashi, Sumida-ku, Tokyo, 130-0022, Japan.

SIGNATURE ABOVE PRINTED NAME (PAYOR / OFW)	Date
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Witnessed by:

P.I.C CORPORATION SIGNATURE ABOVE PRINTED NAME (SOLICITING AGENT)	Date
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