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 – LIBERTY-AMAPHIL

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**

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ELIGIBILITY:

PRINCIPAL (Age 18 – 65 years old) and DEPENDENTS (Age 90 days – 65 years old)				
PLAN	**MAXIMUM BENEFIT LIMIT**	**ANNUAL PREMIUM**	**SEMI-ANNUAL PREMIUM**	**MONTHLY PREMIUM**
WARD	P 70,000	P 12,090	P 6,045	P 1,008
SEMI PRIVATE	100,000	15,479	7,740	1,290
REGULAR PRIVATE	150,000	22,280	11,140	1,857
OPEN PRIVATE	200,000	29,250	14,625	2,438
OPEN PRIVATE	250,000	33,384	16,692	2,783

OVERAGE PRINCIPAL and DEPENDENTS (Age 66 years old – 70 years old)				
PLAN	**MAXIMUM BENEFIT LIMIT**	**ANNUAL PREMIUM**	**SEMI-ANNUAL PREMIUM**	**MONTHLY PREMIUM**
WARD	P 70,000	P 18,136	P 9,068	P 1,512
SEMI PRIVATE	100,000	23,219	11,610	1,935
REGULAR PRIVATE	150,000	33,420	16,710	2,785
OPEN PRIVATE	200,000	43,875	21,938	3,657
OPEN PRIVATE	250,000	50,076	25,038	4,173

OVERAGE PRINCIPAL and DEPENDENTS (Age 71 years old – 75 years old)				
PLAN	**MAXIMUM BENEFIT LIMIT**	**ANNUAL PREMIUM**	**SEMI-ANNUAL PREMIUM**	**MONTHLY PREMIUM**
WARD	P 70,000	P 30,225	P 15,113	P 2,519
SEMI PRIVATE	100,000	38,698	19,349	3,225
REGULAR PRIVATE	150,000	55,700	27,850	4,642
OPEN PRIVATE	200,000	73,125	36,563	6,094
OPEN PRIVATE	250,000	83,460	41,730	6,955

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**.