MAXICARE HEALTHCARE CORPORATION

Agents Accreditation Application Form

APPLICATION REQUIREMENTS		
Eligibility Requirement	**Documentary**	**Process**
Age: 18 to 65 years old Education: finished at least secondary school	○ 2 pcs of 2x2 picture in BLUE background ○ 3 pcs. of 1x1 picture in ANY background ○ Two photocopies of two government issued IDs with visible signature ○ Tax Identification Number	○ Attend the Product Training and pass the Accreditation Examination ○ Review and sign the Service Agreement ○ Pay the Accreditation Fee of P1,000.00 and ATM Deposit fee of P100.00

Kindly fill out the application form completely. For details not applicable, please indicate N/A. Please print on a legal-sized paper.

APPLICATION DETAILS				
APPLYING AS:	❑ Health Benefit Agent	❑ Agency Unit Manager*	❑ Agency Unit Head*	
SOURCE:	❑ Walk-in	❑ Recruited/Referred	❑ On-line	❑ Off-site training
	Referred/Recruited by:			

*applications for Agency Unit Manager and Agency Unit Head would entail additional requirements

PERSONAL DETAILS				
FIRST NAME:				2x2 PICTURE
MIDDLE NAME:				
LAST NAME:		EXTENSION:		
BIRTHDATE:		AGE:		
RESIDENTIAL ADDRESS:	Line 1 Line 2			
POSTAL CODE:				
MOBILE NO:		PHONE NO:		
EMAIL ADD:		SSS NO:		
TIN NO:		GSIS NO:		
CIVIL STATUS:		CITIZENSHIP:		

APPLICANT BACKGROUND								
EDUCATIONAL DETAILS	Attainment	❑ Secondary (High School)		❑ Tertiary (College Degree)		❑ Post-Graduate (Master's / PhD)	
	Institution	School Name		College/University Name		College/University Name	
	Inclusive Dates	Start Date	Graduated Date	Start Date	Graduated Date	Start Date	Graduated Date
	Program						
WORK EXPERIENCE	Company Name	Company 1		Company 2		Company 3	
	Inclusive Dates	Start Date	End Date	Start Date	End Date	Start Date	End Date
	Position	Position at Company 1		Position at Company 2		Position at Company 3	
SALES EXPERIENCE	Company Name	Company 1		Company 2		Company 3	
	Product Carried (Insurance / Manufactured Goods / Services / Etc).						
	Inclusive Years	Start Date	End Date	Start Date	End Date	Start Date	End Date
AFFILIATIONS	Company, Agency, Broker Name	Company 1		Company 2		Company 3	
	Inclusive Dates	Start Date	End Date	Start Date	End Date	Start Date	End Date
	Status	❑ Active	❑Inactive	❑ Active	❑Inactive	❑ Active	❑Inactive

OTHER HMO ACTIVELY CARRIED	
NAME OF HMO	INCLUSIVE DATES

DISCLOSURE OF RELATIONSHIP WITH A MAXICARE EMPLOYEE	
NAME OF RELATIVE	RELATIONSHIP

Please declare any relationship up to a second degree consanguinity and third level of coaffinity.
Eventual discovery of undisclosed relationship and affinity will be subject to investigation and may lead to disaccreditation

I declare that the statements and particulars in this application are true and that no material facts have misstated, misrepresented, or suppressed after enquiry. I agree that this application, together with any other information supplied by me shall form the basis of Maxicare's accreditation validation. I undertake to inform Maxicare of any material alteration to those facts that occurred prior to the approval of my application. I agree that the information I supplied in this application form will be used by Maxicare to fulfill its governmental duties such as, but not limited to tax withholding and income reporting. I also take full accountability and responsibility for any errors in that may occur because of misreporting of the pertinent data.. I agree to be subjected to a full background check. I agree that this application shall become the property of Maxicare, and that Maxicare shall have the right to approve or disapprove this application at its sole discretion, and without obligation to disclose the reason in case of disapproval.

SIGNATURE OVER PRINTED NAME

DATE

Please note that the accreditation is not valid and enforced until the Agent's Service Agreement has been signed by you and the respective signatories of Maxicare Healthcare Corporation

THIS PORTION IS FOR THE ACCREDITATION TEAM

APPLICATION DETAILS				
SUBMISSION DATE			HCB1 DATE	
REQUIREMENT STATUS	Type		Date provided	
	❑ Complete and signed application form			
	❑ 2 pcs of 2x2 picture			
	❑ 3 pcs. of 1x1 picture			
	❑ Tax Identification Number			
	❑ Accreditation Fee			
	❑ Valid ID 1	Type:		
	❑ Valid ID 2:	Type:		
EXAM STATUS	❑ Passed	Score:	❑ Failed	Score:
NEGATIVE RECORDS CHECK STATUS	❑ No-Hit	❑ With Hit	Type of Hit:	
	Supplementary Document Provided		Date Provided:	

AGENCY DECKING DETAILS					
AGENT CODE:					
AGENCY UNIT	AGENCY UNIT MANAGER			AGENCY UNIT HEAD	
SALES HANDLERS	CONSUMER	ACCOUNT OFFICER		CORPORATE	ACCOUNT OFFICER	
		BUSINESS DEVT MNGR			BUSINESS DEVT MNGR	

CERTIFIED COMPLETE BY: ENDORSED BY: APPROVED BY:

Accreditation Assistant

Training and Accreditation Officer

Intermediary Partners Management Manager