

HOLY CROSS SAVINGS & CREDIT COOPERATIVE
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MORTUARY INSURANCE BENEFIT CASH ADVANCE APPLICATION

HEAD OFFICE BRANCH: _____

MEMBER'S PERSONAL INFORMATION

CLIENT NAME: <small>(Surname, Suffix (if any), Given Name, Middle Name)</small>		CLIENT ID:	CONTACT NO.:
ADDRESS:			
DATE OF BIRTH:	AGE:	GENDER:	CIVIL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOW/WIDOWER <input type="checkbox"/> SEPARATED
APPLIED AMOUNT:	SHARE CAPITAL BALANCE:		LOAN BALANCE (if any):

KASUNDUAN at PAGPAPATUNAY

Ang **CASH ADVANCE APPLICATION** na ito ay sinasagot ng aking **MORTUARY INSURANCE BENEFIT** na aking benepisyo bilang isang ganap na kasapi o *Full-Fledged Member* ng kooperatibang ito. Subalit kung sakali man na ang aking *Membership Account* ay maisara, kusa man o sa ano pa mang kadahilanan, ang nasabing halaga na aking nai-CASH ADVANCE ay kasamang ibabawas sa aking mga Deposito at/o iba pang benepisyo. Pero sa pagkakataon na ang aking Deposito at Benepisyo ay hindi sasapat upang tugunan ang aking nai-CASH ADVANCE, ito ay aking babayaran ng **CASH**.

Lubos kong nalalaman at nauunawaan ang lahat ng nakasaad sa kasulatang ito at walang anuman o sinuman ang pumilit sa akin upang lagdaan ang kasunduang ito. Gayundin, pinatutunayan ko na ang lahat ng impormasyong isinulat ko sa kasulatang ito ay totoo at tama sa abot ng aking nalalaman.

MEMBER

WITNESS/RELATIONSHIP

AUTHORIZED CLAIMANT (if representative)

Signature over Printed Name/Date

Signature over Printed Name/Date

Signature over Printed Name/Date

(FOR HCSCCO USE ONLY)

APPROVED CASH ADVANCE: P

SUBMITTED DOCUMENTS	DATE/TIME	REMARKS	INITIALS
I. Received By:			
II. Checked By:			
III. Verified By:			
IV. Recommended By:			
1. Branch Operations Area Manager			
2. Membership & Marketing Manager			
3. Credit & Collection Manager			
4. Accounting & Finance Manager			
V. Approved for Release By:			
1. Chief Executive Officer			

CHECK PAYABLE TO: _____

NOTE: Cash Advance limit is at maximum of P25,000.00 or equal to Member's Share Capital Balance, whichever is lower, minimum of P5,000.00 SC. One-time Cash Advance only. Three (3) working days processing after all requirements were completely complied. This application is subject for assessment & approval. Other Terms & Conditions apply.

REQUIREMENTS:

REMARKS

1. Original Copy or Certified True Copy (CTC) of Medical Certificate with Diagnosis. _____
2. Original Copy/CTC/Photocopy of Medical Abstract or Discharge Summary with Confinement Date or Photocopy of Prescription Medicines of Physician. _____
3. Photocopy of Two Valid IDs of Member & his/her Authorized Claimant. _____
4. Original Authorization Letter to file and/or receive and encash the APPROVED CASH ADVANCE of Member. _____
(Note: Subject for Verification of C.I with attached Report and Documentation.)
5. Print-out of Member's Summary of Account and its Mortuary Fund Subsidiary Ledger (SL). _____
6. Print-out of CLIMBS GRTL. _____

OTHER REQUIREMENTS AS PRESCRIBED BY HCSCCO OFFICER:

NOTES:

VERIFICATION REPORT:

Verified By:

Conformed & Witnessed By:

Signature over Printed Name/Date

Signature over Printed Name/Relationship

Date