medicareplus
Beyond Healthcare . . . Lasting Wellness

FRANCHISE REQUEST FORM

FRANCHISE NO.	
DATE SUBMITTED	

FULL NAME OF THE COMPANY	SHORT NAME OF THE COMPANY / ALIAS
AFFILIATES / SISTER COMPANIES	

BUSINESS / OFFICE ADDRESS

ADDRESS		
NATURE OF BUSINESS/INDUSTRY*		NO. OF YEARS IN OPERATION
CONTACT PERSON		DESIGNATION
TELEPHONE NO.	FAX NO.	E-MAIL ADDRESS
PROPOSAL ADDRESEE		DESIGNATION
DECISION MAKER(S)		DESIGNATION

NO. OF EMPLOYEES ACCORDING TO RANK CLASSIFICATION

TOTAL NO. OF REGULAR EMPLOYEES	NO. OF DEPENDENTS	NO. OF EMPLOYEES WHO ARE FOREIGNERS/EXPATRIATES

TYPE OF COVERAGE:

☐ Non-contributory (Fully paid by the company)
☐ Contributory (Paid both by the company and employee)
☐ Salary allotment (Fully paid by the employee)

ARE EMPLOYEES COVERED BY PHILHEALTH?	WITH FOREIGN EMPLOYEES/EXPATRIATES	NATIONALITY/POSITIONS OF EXPATRIATES

☐ Standard Proposal

☐ SPECIAL ARRANGEMENT for Customized Proposal

**PLEASE WRITE LEGIBLY*

REQUIREMENTS:

☐ Census list including name and/or employee number, date of birth and position of all eligible employees.
☐ Utilization Report, if account has an existing HMO coverage with the company.
☐ Terms of Reference, if the company has an existing health care provider

SALES ASSOCIATE DATA

NAME OF SALES ASSOCIATE		SA CODE
HOME/ BUSINESS ADDRESS		TELEPHONE NO. / MOBILE NO.
GM*	ARM*	BUSINESS NO./ MOBILE NO.

CONFORME:

It is hereby understood that I am given a maximum of thirty (30) days to franchise this account. After thirty days, my franchise will **AUTOMATICALLY EXPIRE** if no written request is submitted.

TO BE ACCOMPLISHED BY THE FRANCHISING OFFICER

☐ Franchise is approved
☐ Declined due to _____
☐ On hold due to _____

NAME & SIGNATURE DATE

_____
SIGNATURE OF SALES ASSOCIATE