CEBU CFI COMMUNITY COOPERATIVE

Esperanza Fiel Garcia Bldg., Cebu Capitol Compound,
Capitol, Cebu City, Philippines 6000

APPLICATION FOR TRANSFER

Of Mutual Medical Assistance Fund Insurance

CFI COOP MEMBER DETAILS

Name of CFI COOP Member: _____

Account Status: _____

Date of Set-up: _____

Period Covered: _____

Coverage: _____

DETAILS OF THE DEPENDENT

Name: _____ **Date of Birth:** _____

Address: _____

Contact Number: _____ **Civil Status:** _____

Email Address: _____

Relationship to the COOP Member: _____

Period Covered: _____

Coverage: _____

Requirements Checklist:

Healthcare Application Form

Dependent/Recipient

- Child/Parent- Birth Certificate
- Spouse- Birth Certificate and Marriage Certificate

Proof of Coverage from other Healthcare Provider (Certification)

Application for Transfer Form

Age limit of recipient: **1-59 years** old only

Immediate Family only

- If married, member can reassign the coverage to his/her spouse or child or any of his/her parents
- If single, member can reassign the coverage to his/her mother

☐ **I hereby authorize Cebu CFI Coop to reassign my MMAF Insurance coverage to the above mentioned dependent. I am fully aware that once my healthcare coverage is transferred, I can no longer avail of any MMAF services for the particular period covered.**

☐ **Furthermore, I hereby acknowledge that this reassignment of MMAF Insurance is only valid for 1 year and renewal of this agreement is not automatic.**

_____ _____

Signature over Printed Name **Date Signed**

Received by: _____Verified by: _____ Approved by: _____

(Clinic Staff) (Clinic Manager) (President/CEO)

MEDO:

Set-up of transferor: (name of member) _____

MEDO personnel: _____ MEDO Division Chief: _____