[24]7

24/7 CUSTOMER PHILIPPINES, INC.
CRITICAL ILLNESS BENEFIT PLAN via ACE-INA
(Contract Year: Jan 1, 2013 – Dec 31, 2013)
ENROLLMENT FORM - FOR SPOUSE ONLY
(Copy of marriage certificate is required)

Employee Number (of Principal Member)	Last Name of Employee	First Name of Employee	Middle Initial of Employee	Extension Name(Jr., III)
Birth Date and Age of Spouse (mm/dd/yyyy)	Full Name of Spouse	Sex of Sopuse ☐ Male ☐ Female	Job Grade of Employee ☐ I ☐ J ☐ A ☐ B ☐ C ☐ D	

INFORMATION ON EMPLOYEE:

[ ] **ENROLL MY SPOUSE** - This is to confirm that I am enrolled under the Critical Illness Benefit Plan and wish to enroll my spouse under the same benefit. This serves as a continuing authorization for the Company to effect the semi-monthly deductions based on the annual premium below.

[ ] **ENROLL MYSELF AND MY SPOUSE** - I wish to enroll myself under the Critical Illness Benefit Plan. Details of my coverage are based on the attached application form for employees. This serves as a continuing authorization for the Company to effect the semi-monthly deductions based on the annual premium below:

Spouse (Age Band)	PLAN A 100,000	PLAN B 200,000	PLAN C 300,000	PLAN D 400,000	PLAN E 500,000	PLAN F 600,000	PLAN G 800,000	PLAN H 1,000,000
18-29	404	807	1,210	1,613	2,016	2,418	3,224	4,030
30-34	781	1,560	2,340	3,120	3,899	4,679	6,239	7,797
35-39	1,353	2,705	4,057	5,410	6,762	8,114	10,819	13,522
40-44	2,692	5,383	8,074	10,765	13,456	16,147	21,529	26,910
45-49	4,530	9,059	13,588	18,116	22,645	27,174	36,231	45,288
50-54	7,032	14,063	21,095	28,125	35,156	42,188	56,250	70,312
55-59	10,679	21,357	32,035	42,713	53,391	64,069	85,426	106,781
60-64	15,724	31,447	47,170	62,893	78,617	94,339	125,785	157,232

Please encircle the chosen annual premium within the age range of your spouse. This annual premium will be deducted on a staggered basis starting on the effective date of your spouse's CRIB coverage until the end of this contract period.

Only an employee's legal spouse is eligible to enroll under the Plan. The conditions of the Critical Illness Benefit Plan are, as follows:

- The Employee/Principal Member coverage under the plan is a pre-requisite for the spouse's enrollment under this benefit.
- The spouse's enrollment will be processed upon completion of this form and submission of a copy of the employee's marriage certificate.
- The plan pays for expenses incurred for a critical illness even if the insured has HMO coverage.
- Members may choose amount of coverage at the onset of the coverage.
- Pre-Existing Illnesses are not covered under the plan.
- The first diagnosis of the critical illness should not be within 90 days from effective date of coverage in order to be eligible of the benefit.
- Request for upgrade of coverage is subject to the approval of ACE Insurance. Any approved upgrade will not commence until 90 days after the effective date of the upgrade in plan.
- Upon diagnosis of a critical illness, a member must survive for a period of 30 days from the date of the diagnosis.
- Only 1 benefit payment shall be provided during the member's lifetime regardless of the number of critical illness suffered.
- Requests to cancel shall be entertained only upon contract expiry or upon resignation/separation of the principal member/employee from the Company.
- The plan shall cover only the following conditions: cancer, myocardial infarction, kidney failure, stroke, coronary artery bypass surgery, paralysis, major organ transplantation, muscular dystrophy, amyotrophic lateral sclerosis, aplastic anaemia, bacterial meningitis, benign brain tumor, blindness, coma, fulminant viral hepatitis, heart valve replacement, liver failure, loss of hearing, loss of limbs, loss of speech, major burns, motor neuron disease, Parkinson's disease, poliomyelitis, primary pulmonary arterial hypertension, progressive bulbar palsy, progressive muscular atrophy, severe brain damage, surgery to aorta and terminal illness.

I certify that the information that I have provided above are true and correct to the best of my knowledge, and have followed the guidelines on enrollment stated above. I understand that my providing any false information will invalidate my spouse's coverage. I authorize the Company and ACE-INA to obtain a copy of all pertinent medical information of my spouse in the course of my membership in the Plan.

Employee's Signature _____ Date _____ Received by OHCD / Date _____