LETTER REQUEST FOR REINSTATEMENT OF MEMBERSHIP UNDER MUTUAL AID SYSTEM (MAS) 65 AND/OR MUTUAL RETIREMENT BENEFIT SYSTEM (MRBS) PLUS

Date : ______________________________

To : **PHILIPPINE PUBLIC SCHOOL TEACHERS ASSOCIATION**
245 Banawe Street, Quezon City

This is to request from your good office for the reinstatement of my plan membership under:

(Please check the appropriate box, where applicable. Take note that re-dating of policy can only be done once and the monthly premium contribution may be adjusted accordingly in case of change in age. Also, once re-dated previous contributions will be forfeited.)

☐ **Mutual Aid System (MAS) 65** **Policy Number** ___________________
By ☐ **Updating of Arrears** ☐ **Re-dating**

☐ **Mutual Retirement Benefit System (MRBS) Plus** **Policy Number** ___________________
By ☐ **Updating of Arrears** ☐ **Re-dating**

As evidence of my insurability, I am submitting herewith the following:

☐ **Duly Accomplished Personal Health Questionnaire and Declaration Form.** **(For walk-in applicants below 50 years old)**
☐ **Dully Accomplished Full Medical Examination Form signed by a licensed government physician**.

I understand that the approval of my application for reinstatement will depend on the submitted documents and full payment of all contribution arrears, indebtedness or deficiency in my plan membership plus overdue interest and advance premium payment, as indicated in the given Statement of Accounts

Further, I understand that the effectivity of my plan membership reinstatement will take effect one (1) month from the date of approval and shall be incontestable after it shall have been in force for a period of two (2) years from the date of reinstatement during my lifetime.

______________________________ Member's Signature-Over-Printed Name

______________________________ Date of Birth

______________________________ Address

______________________________ Contact Number/s

FOR PPSTA USE ONLY

APPLICATION NO. : _______ -_____-________________

Received by : _______________ **Date:** ___________ **From :** ____________________

(Check if complied already.)

☐ **Personal Health Questionnaire and Declaration Form**
☐ Approved _____________ ☐ Disapproved ______________

☐ **Full Medical Examination Form**
☐ Approved ____________ ☐ Disapproved ______________

☐ **Full Payment of Arrears**
☐ Direct Payment ☐ Deducted from SSL

☐ **Advance Premium Deposit**
☐ Direct Payment ☐ Salary Deduction ________________

Remarks :

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Processing Officer

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Approving Officer