

**Manulife China Bank Life Assurance Corporation**  
Head Office: NEX Tower, 6786 Ayala Ave., Makati, 1229 Metro Manila  
Customer Care: +632 8884-7000  
Domestic Toll-Free: 1-800-1-888 6268  
Website: www.manulife-chinabank.com.ph  
Email: phcustomer@manulife.com

# Authorization for Post Dated Check (PDC) Pull Out

In this form, "you", "your" and "the Company" mean Manulife China Bank Life Assurance Corporation. "I", "me" and "my" mean the Policyowner.

Policyowner Name: (Last Name, First Name), (Middle Name <input type="checkbox"/> do not know /not applicable)		Policy No/s
Email Address		Mobile Number (Country Code, Area Code, Telephone Number)

Request Date (mm/dd/yyyy): \_\_\_\_\_

I hereby authorize my servicing Financial Sales Associate, \_\_\_\_\_ to pull out the postdated checks from (date & check number/s) \_\_\_\_\_ to \_\_\_\_\_

which I have issued to pay for my premium due/s for the reason/s below:

Account Closed \_\_\_\_\_ Insufficient Funds \_\_\_\_\_ Pay in cash \_\_\_\_\_ Mode change from \_\_\_\_\_ to \_\_\_\_\_

I will replace checks on (mm/dd/yyyy): \_\_\_\_\_

Others: \_\_\_\_\_

By signing this form, I allow the Company, including its affiliates, subsidiaries, service providers or any member of the Manulife Financial Group to process, collect, store, use, share or transfer all personal data I have provided for the purposes stated in the Company's Customer Privacy Policy found in your website, <https://www.manulife-chinabank.com.ph/Customer-Privacy-Policy>. I confirm that the information I provided is complete and true. I also allow the Company to update my records based on the information found in this form and to use such to administer and service my policy. During the effectivity of the contract/policy, I agree to the following: in case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to my fault, the Company may apply the following: (a) measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

Signature of Policyowner over printed name	Date Signed(mm/dd/yyyy)	Place Signed(mm/dd/yyyy)	Signature of Financial Sales Associate over printed name	Date Signed(mm/dd/yyyy)	Place Signed(mm/dd/yyyy)
Authorized Signatory over printed name	Date Signed(mm/dd/yyyy)	Place Signed(mm/dd/yyyy)	For Billing and Collections Use Only	Date Signed(mm/dd/yyyy)	Place Signed(mm/dd/yyyy)
NOTE:			Signatures verified by: (signature over printed name)		

1. Request for PDC pull out should be signed and submitted 5 banking days before the date of check.
2. For policyowner signature - please attach a photo copy of any valid ID.
3. For Customer Service Officer (CSO)/ Sales Admin - please verify customer and/or FSA signature before sending to PDC custodian.

Form No. MCBL BC APDCPO (v. 05/2021)

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