Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

APPLICATION FOR TOP-UP PREMIUM

1. General Information

Name of Life Insured (Last, First, MI) | Place of birth | Citizenship

Name of Policy Owner, if different from Life Insured, (Last, First, MI) | Place of birth | Citizenship

Mailing Address | Policy Number

Address Abroad (If applicable) | Email Address

Telephone No./Mobile | Telephone No. Abroad (if applicable) | Occupation | TIN

CS-MCB011-2016

2. Details of Top-Up

Payment Mode ▱ Cash ▱ Check ▱ From another policy

Fund Allocation	Amount/Percentage	Fund Allocation	Amount/Percentage
Peso Bond Fund / Peso Secure Fund		USD Bond Fund / USD Secure Fund	
Peso Stable Fund / Peso Diversified Value Fund		USD Asia Pacific Bond Fund	
Peso Balanced Fund / Peso Dynamic Allocation Fund		USD ASEAN Growth Fund	
Peso Equity Fund / Peso Growth Fund		USD Global Target Income Fund	
Peso Target Income Fund / Peso Target Distribution Fund		Others	

Details specific to Peso Target Income Fund/Peso Target Distribution Fund

Income Payout Option ☐ *Cash* ☐ *Reinvestment*
Payout Frequency ☐ *Annual* ☐ *Semi-Annual* ☐ *Quarterly* ☐ *Monthly*
Payout Start Date Start of the _____ policy month

Others _____

3. Declaration of Insurability

1. Has your mother or father, or any brother or sister had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problems, stroke, haemochromotosis, Huntington's disease, polycystic kidney, multiple sclerosis, Parkinson's or any other hereditary disease?
   ▱ Yes ▱ No

Family Member (Relationship to you)	Condition/Illness (Cancer/heart disease, specify type)	Age at onset of illness	Age at death (if applicable)

2. Present Weight ▱ Kg ▱ Lbs
3. Present Height ▱ Ft/in ▱ Cm

Number the answers to correspond the questions. Give full particulars, conditions, dates, durations and results. Give full name and address of doctors, hospitals and clinics.

	Yes	No
4. Have you ever had or received treatment for diabetes, high cholesterol, high blood pressure, heart attack, stroke or any other heart or blood vessel disorder?	▱	▱
5. Have you ever had or received treatment for cancer or growth of any kind, any breast lump or abnormality, breast examination, ultrasound or mammogram or an abnormal cervical smear test?	▱	▱
6. Have you ever had or received treatment for hepatitis, mental illness, epilepsy, HIV or AIDS or any disorder of the lungs, kidneys, liver or any other illness or physical disability?	▱	▱
7. Have you in the last 5 years consulted any doctor and/or been advised to have any diagnostic test, hospital confinement or surgical operation or are you currently taking any medication?	▱	▱
8. Do you participate or intend to participate in aviation (other than as a fare paying passenger), motor car or cycle racing, scuba diving or any other hazardous sport or activity?	▱	▱
9. A. Do you drink alcohol? Type _____ Quantity per day _____ B. Have you ever used or injected yourself with any illegal or illicit drugs?	▱	▱

10. Will anyone other than the Insured/Owner be paying for this policy? ▱ Yes ▱ No

11. Has the Insured/Owner or any direct relative of either person ever held a senior position in the government, a political party, the military, any tribunal or government-owned corporation? ▱ Yes ▱ No

Source of Income | Estimated Net Worth

4. Declaration

1. I/We represent that the foregoing statements are true and complete and that all exceptions have been stated.
2. I/We authorize the Company to deduct any bank and transaction charges in addition to loading fees from top-up premium prior to investment.
3. I/We agree that the investment to US Dollar Variable Life fund for cheque payments will take effect on the later of 30 days after payment or when cheque payment has been cleared.
4. I/We further agree that the above transaction shall be an amendment to and form part of the original application of the Policy Issued thereunder, if any, and that they shall be binding on any person who shall have or claim any interest under such Policy Agreement.
5. I/We agree that this request and any evidence of insurability which may be required in connection with the change requested shall be considered an amendment and supplement to the original application and shall form a part of the Policy, that if evidence of insurability is required, the change requested shall not be effective until it has been approved at the Home Office and the required additional premium has been paid.
6. In case of apparent errors or ommissions discovered by the Company in the foregoing request, I/we hereby authorize Manulife Philippines to correct or complete this request for amendment for Policy and I/we agree that if the Policy/Agreement is changed in accordance with such amended request, my/our acceptance of any Policy/Agreement so amended or reissued will constitute my/our conformity to and ratification of any correction in or addition to this request made by the said Company in the space provided for.

5. Signatures

Date signed | Place signed | Name and signature of Life Insured

Name and signature of Policy Owner/Payor | Name and signature of FSA/Witness | Agent's Code

Manulife Chinabank Life Assurance Corporation
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4. Non-Med Form

DECLARATION OF INSURABILITY OF PROPOSED INSURED OR PAYOR IN LIEU OF MEDICAL EXAMINATION (AGES 51 TO 59)

1. Has your mother or father, or any brother or sister had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problems, stroke, haemochromotosis, Huntington's disease, polycystic kidney, multiple sclerosis, Parkinson's or any other hereditary disease?

☐ Yes ☐ No

Family Member (Relationship to you)	Condition/Illness (Cancer/heart disease, specify type)	Age at onset of illness	Age at death (if applicable)

2. Present Weight	3. Present Height

Number the answers to correspond the questions. Give full particulars, conditions, dates, durations and results. Give full name and address of doctors, hospitals and clinics.

4. SO FAR AS YOU KNOW, HAVE YOU EVER HAD ANY DISTURBANCE OF:	No	Yes
A The HEART, BLOOD VESSELS, such as: (1) Congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rhuematic fever or poor circulation?		
(2) Heart attack, angina or chest pain or discomfort or any other heart disease?		
(3) High blood pressure?		
(4) Have you had any electrocardiograms, when, why, result?		
B The NOSE, THROAT, LUNGS, such as Asthma, tuberculosis, chronic bronchitis, blood spitting, pleurisy, emphysema?		
C The ABDOMINAL ORGANS, such as: (1) Hepatitis? Or found to be positive for Hepatitis virus?		
(2) Ulcer, Colitis bleeding, Diverticulitis, Jaundice, Liver disease, Tumors?		
D The KIDNEYS, BLADDER, GENITAL ORGANS, such as inflammation, stone, sugar, albumin, blood or pus in the urine?		
E The NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, nervous breakdown, impairment of sight or hearing?		
F The GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy?		
G The MUSCULO-SKELETAL SYSTEM such as any injury, skin, muscles, bones and joints, congenital deformity, congenital abnormality, nephritis, cerebral palsy, emotional disturbance spells, or disorder of the muscles, bones, joint or spine? Amputation, paralysis or deformity?		
5. Have you ever had or received treatment for CANCER, TUMOR OR GROWTH of any kind?		
6. Have you had any form of sexually transmitted disease? Is there anything about your lifestyle which could expose you to risks of AIDS?		
7. Are you suffering from AIDS? Have you had any test results indicating exposure to AIDS virus?		
8. Has your weight changed more than 10 lbs. (4.5 kg) in the past year?		
9. So far as you know, have you had any illness or injury in the last 5 years not mentioned above?		
10. Have you had any X-rays during the last 5 years? Give reasons and results.		
11. A. Have you had any illness, injury, operation, treatment, hospital care or medical examination during the last 5 years not mentioned above?		
B. Has any further care been recommended?		
12. Do you now have any disease or symptoms of disease?		
13. Are you currently receiving any treatment or taking any medication?		
14. A. Do you consume alcohol beverages? If so, how much? [_____]		
B. Have you been treated for alcohol or drug abuse during the last 5 years?		
15. Have you smoked cigarettes or tobacco in any form within the past year? If yes, A. Average number of sticks daily [_____] B. How may years have you smoked cigarettes or tobacco?		
ADDITIONAL QUESTIONS FOR WOMEN: 16. Have you ever suffered from or are you aware of any breast lump or any other disorders of the breast?		
17. Have you ever had an abnormal pap smear, or mammogram, ultrasound of the breast, pelvis or any other gynecological investigation or been advised to repeat this test for investigation within the next 12 months?		
18. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?		
19. Any miscarriage or complications of pregnancy?		
20. Are you pregnant? If so, how many months? [_____] months.		

I have read the above questions, statements and answers and they are complete and true to the best of my knowledge and belief. I hereby agree that they shall form part of the application for life insurance for which this declaration of insurability was required by the MANUFACTURERS LIFE INSURANCE COMPANY (PHILIPPINES), Inc.

5. Signatures

Date signed	Place signed	Name and signature of Life Insured
Name and signature of Policy Owner/Payor	Name and signature of FSA/Witness	Agent's Code