Manulife China Bank
LIFE ASSURANCE CORPORATION

Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 888 6268
Website: www.manulife-chinabank.com.ph
Email: phcustomercare@manulife.com

Life Insurance Application

☐ Variable Life ☐ Traditional

Policy No. ______________________

Please answer completely and accurately and in CAPITAL letters. Answer all fields, put "N/A" if not applicable. Use black ink. Do not use friction pens. Any change should be counter-signed by Proposed Insured and/or Owner/Payor. In this form, "you" and "your" means the Proposed Insured and/or Owner/Payor as applicable. "We", "us", "our" and "the Company" means Manulife China Bank Life Assurance Corporation.

Personal Information

Proposed Insured	Owner/Payor (if different from Proposed Insured)
1. Last Name	2. Last Name
3. First Name	4. First Name
5. Middle Name ☐ Do not know / not applicable	6. Middle Name ☐ Do not know / not applicable
7. Other Name/s (Alias/es, if any)	8. Other Name/s (Alias/es, if any)
9. Date of Birth (mm/dd/yyyy) · 10. Sex ☐ Male ☐ Female · 11. Civil Status ☐ Single ☐ Married ☐ Other:	12. Date of Birth (mm/dd/yyyy) · 13. Sex ☐ Male ☐ Female · 14. Civil Status ☐ Single ☐ Married ☐ Other:
15. Country of Birth ☐ Philippines ☐ Other:	16. Country of Birth ☐ Philippines ☐ Other:
17. City/Municipality of Birth	18. City/Municipality of Birth
19. Citizenship/s (indicate all) ☐ Filipino ☐ Other:	20. Citizenship/s (indicate all) ☐ Filipino ☐ Other:
21. Nationality (if other than Citizenship)	22. Nationality (if other than Citizenship)
23. For Philippine Nationals (please provide both) ☐ National ID or ☐ SSS or ☐ GSIS or ☐ UMID ID Tax Identification Number (TIN)	24. For Philippine Nationals (please provide both) ☐ National ID or ☐ SSS or ☐ GSIS or ☐ UMID ID Tax Identification Number (TIN)
25. For Foreign Nationals: ☐ ACR Number or ☐ SIRV/SRRV Number Expiry: ________	26. For Foreign Nationals: ☐ ACR Number or ☐ SIRV/SRRV Number Expiry: ________
27. Occupation (Job Title & Functions) · 28. Tenure Years: ____ Months: ____	29. Occupation (Job Title & Functions) · 30. Tenure Years: ____ Months: ____
31. Employer/Business Name · 32. Nature of Business/Industry	33. Employer/Business Name · 34. Nature of Business/Industry
35. Other Occupation/s	36. Other Occupation/s

37. Estimated Annual Income	38. Estimated Annual Income
39. Sources of Funds ☐ Salary ☐ Business ☐ Savings Remittances (country): ______ Other: ______	40. Sources of Funds ☐ Salary ☐ Business ☐ Savings Remittances (country): ______ Other: ______
41. Have you or any of your immediate family members or close relationships and associates been entrusted with prominent public position/s in (a) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (b) a foreign State; or (c) an international organization? ☐ Yes ☐ No	42. Have you or any of your immediate family members or close relationships and associates been entrusted with prominent public position/s in (a) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (b) a foreign State; or (c) an international organization? ☐ Yes ☐ No

Owner Information

43. Is the Owner a United States citizen, resident, or a resident alien (US Green card holder)? ☐ Yes to any, please provide W-9 form and skip question 45 ☐ No	44. If Owner is different from the Proposed Insured: I am the Proposed Insured's: ______ If Owner is Fiance/Fiancee of the Proposed Insured, will there be legal marriage w/in 12 months? ☐ Yes ☐ No
45. Does the Owner have a United States Taxpayer Identification Number (SSN/TIN), address, telephone number? Or was the Owner born in the US? ☐ Yes to any, please provide W8-BEN form ☐ No	46. What is your purpose of getting an insurance policy? ☐ Protection ☐ Mortgage Redemption ☐ Education ☐ Savings ☐ Investment

47. Does this policy have a Beneficial Owner?
☐ Yes, please submit Beneficial Owner form ☐ No

Contingent Owner (if any)

48. Name (Last Name, First Name) (Middle Name) ☐ Do not know / not applicable	Date of Birth (mm/dd/yyyy)	Sex	The Contingent Owner is the Proposed Insured's (state relationship):

Contact Information

Proposed Insured	Owner/Payor (if different from Proposed Insured)
49. Mobile Number (ex: +639171234567) +63 ______ International Mobile Number ______ Country Code Area Code Telephone Number ☐ I want to receive marketing messages via SMS	50. Mobile Number (ex: +639171234567) +63 ______ International Mobile Number ______ Country Code Area Code Telephone Number ☐ I want to receive marketing messages via SMS
51. Email Address ☐ I want to receive marketing messages via email	52. Email Address ☐ I want to receive marketing messages via email
53. Present Address ______ Floor/No., Building/Street, Subdivision/Village ______ Barangay/District, Town/City ______ Province/State, Country, Zip Code	54. Present Address ______ Floor/No., Building/Street, Subdivision/Village ______ Barangay/District, Town/City ______ Province/State, Country, Zip Code

55. Office Address ☐ Same as Present Address

Floor/No., Building/Street, Subdivision/Village

Barangay/District, Town/City

Province/State, Country, Zip Code

56. Office Address ☐ Same as Present Address

Floor/No., Building/Street, Subdivision/Village

Barangay/District, Town/City

Province/State, Country, Zip Code

57. Preferred Mailing Address (choose one) ☐ Present Address ☐ Office Address
(to be used if the need to send a printed document arises)

Policy Information

58. Policy Name

59. Mode of Payment
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

60. Initial Payment
☐ Credit Card ☐ Check ☐ Other: ____________
Amount ____________ Date ____________

61. Will anyone other than the Proposed Insured and/or Owner be paying for this policy?
☐ Yes (please submit Payor Information Form) ☐ No

62. Regular Payment Options
(additional forms may be needed)
☐ Credit Card ☐ Auto-debit Arrangement
☐ Post-dated Checks:
APDC#: ____________

63. Benefit Payout
Bank: ☐ China Bank ☐ China Bank Savings
Currency: ☐ Peso ☐ Dollar
Account No. ____________
Account Name ____________

64. Dividend Option (For Dividend-earning policies only)
☐ Accumulate with interest* ☐ Paid in Cash
☐ Pay future premiums ☐ Other:
☐ Purchase Paid-up Additions ____________

*Default

65. What will happen if your premium is unpaid
☐ Loan from policy ☐ Reduced Paid-up Insurance*
☐ Surrender for Cash Value

*Default

Actual options may vary depending on the terms of your policy contract

Primary Beneficiary Information

Name (Last Name, First Name) (Middle Name) ☐ Do not know / not applicable	Address (No., Street, Village, City/Municipality, Province/State, Country, Zip Code)	Contact Number Mobile: (Country Code + Mobile No.)	% of Share	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Sex	Citizenship/ Nationality (indicate all)	Place/ Country of Birth	Irrevocable? Yes No
									☐ ☐
									☐ ☐
									☐ ☐
									☐ ☐
									☐ ☐
									☐ ☐

Contingent Beneficiary

Name (Last Name, First Name) (Middle Name) ☐ Do not know / not applicable	Address (No., Street, Village, City/Municipality, Province/State, Country, Zip Code)	Contact Number Mobile: (Country Code + Mobile No.)	% of Share	Relationship to Proposed Insured	Date of Birth (mm/dd/yyyy)	Sex	Citizenship/ Nationality (indicate all)	Place/ Country of Birth	Irrevocable? Yes No
									☐ ☐
									☐ ☐
									☐ ☐

If the beneficiary is a Fiancé/Fiancée of the Proposed Insured, will there be legal marriage within the next 12 months?
☐ Yes ☐ No

Trustee Information (if any of the beneficiary/ies are minors)

Name (Last Name, First Name) (Middle Name) ☐ Do not know / not applicable	Address (No., Street, Village, City/Municipality, Province/State, Country, Zip Code)	Sex	Contact Number Mobile: (Country Code + Mobile No.)	Relationship to Minor Beneficiary	Date of Birth (mm/dd/yyyy)	Citizenship/ Nationality (indicate all)	Place/ Country of Birth

Important Note:

A beneficiary is revocable unless specified as irrevocable. If you designate an irrevocable beneficiary, you cannot make any changes under the policy that will adversely affect the ownership interests of the irrevocable beneficiary, without the written consent of the irrevocable beneficiary/ies.

Life Insurance Questions

	Proposed Insured	**Owner/ Payor**	**Details** (Write the question number and indicate if it's for the Proposed Insured or Payor. Provide the conditions, dates, durations, results, full name and address of doctors, hospitals and clinics)
66. Current Height:	☐ ft/in ☐ cm	☐ ft/in ☐ cm	
67. Current Weight:	☐ lbs ☐ kg	☐ lbs ☐ kg	
68. How do you describe your current drinking habit?	☐ Never drink ☐ Less than 15 bottles of beer (or 3 bottles of wine) per week ☐ 15 or more bottles of beer (3 bottles of wine) per week	☐ Never drink ☐ Less than 15 bottles of beer (or 3 bottles of wine) per week ☐ 15 or more bottles of beer (3 bottles of wine) per week	
69. How do you describe your current smoking habit?	☐ Never smoke ☐ Less than 31 sticks of cigarettes per day ☐ 31 or more sticks of cigarettes per day	☐ Never smoke ☐ Less than 31 sticks of cigarettes per day ☐ 31 or more sticks of cigarettes per day	

	Proposed Insured	Owner/ Payor	Details (Write the question number and indicate if it's for the Proposed Insured or Payor. Provide the conditions, dates, durations, results, full name and address of doctors, hospitals and clinics)
70. Have you ever applied for a life insurance policy or reinstatement which was declined, postponed, cancelled or modified in type, coverage or rate? If yes, please state insurance companies, dates and details.	☐Yes ☐No	☐Yes ☐No	
71. Do you engage or have definite plans to engage in any mountaineering, sky diving, scuba diving, hazardous sports, racing or flying other than as a fare paying passenger or on a regularly scheduled airline? If yes, complete appropriate questionnaire.	☐Yes ☐No	☐Yes ☐No	
72. Do you have plans to travel, work or reside abroad for more than six(6) months? If yes, provide details.	☐Yes ☐No	☐Yes ☐No	
73. Have you ever had or currently having any disease or disorder of: a. the HEART, BLOOD VESSELS, such as congenital heart disease, heart murmur, shortness of breath, swelling of ankles, irregular pulse, rheumatic fever, poor circulation, heart attack, angina or chest pain or discomfort, high blood pressure, or any other heart disease?	☐Yes ☐No	☐Yes ☐No	
b. the NOSE, THROAT, LUNGS, such as asthma, tuberculosis, chronic bronchitis, blood spitting or any other respiratory disease (except common cold and flu)?	☐Yes ☐No	☐Yes ☐No	
c. the ABDOMINAL ORGANS, such as hepatitis, positive for hepatitis virus, ulcer, colitis bleeding, diverticulitis, jaundice, liver disease, tumors or any other gastrointestinal disease (except acute gastroenteritis which has recovered)?	☐Yes ☐No	☐Yes ☐No	
d. the KIDNEYS, BLADDER, REPRODUCTIVE ORGANS, SEXUALLY TRANSMITTED DISEASES, such as irregular menstrual bleeding, prostate hyperplasia, fibroids, inflammation, stone, sugar, albumin, blood or pus in the urine or any other genito-urinary, reproductive, sexually transmitted disease?	☐Yes ☐No	☐Yes ☐No	
e. the NERVOUS SYSTEM, EYES, EARS, such as convulsions, stroke, seizures, impairment of sight or hearing, or nervous disorder, ear, eye disease (except nearsightedness, farsightedness, astigmatism, color blindness)?	☐Yes ☐No	☐Yes ☐No	
f. the GLANDULAR SYSTEM, BLOOD such as diabetes, gout, enlarged glands, goiter, anemia, disorder of breasts, skin condition or allergy or any other disorder of the glands or blood?	☐Yes ☐No	☐Yes ☐No	

	Proposed Insured	Owner/ Payor	Details (Write the question number and indicate if it's for the Proposed Insured or Payor. Provide the conditions, dates, durations, results, full name and address of doctors, hospitals and clinics)
g. the MUSCULO-SKELETAL SYSTEM such as any injury, muscles, bones and joints, congenital deformity, congenital abnormality, or disorder of the muscles, bones, joints or spine? Amputation, paralysis, deformity (except sprains and strains which have recovered)?	☐Yes ☐No	☐Yes ☐No	
h. CANCER, such as bladder cancer, breast cancer, colon cancer, cervical cancer, liver cancer, lung cancer, stomach cancer and any other cancers?	☐Yes ☐No	☐Yes ☐No	
i. MOOD, MENTAL, such as depression, anxiety, nervous breakdown, schizophrenia, bipolar disorder, phobia or any other mood or mental disorder?	☐Yes ☐No	☐Yes ☐No	
74. Is there anything about your lifestyle which could expose you to risks of AIDS?	☐Yes ☐No	☐Yes ☐No	
75. Are you suffering from AIDS? Have you had any results indicating exposure to the AIDS virus?	☐Yes ☐No	☐Yes ☐No	
76. Has your weight changed more than 10lbs. (4.5kg) in the past year?	☐Yes ☐No	☐Yes ☐No	
77. Have you had any illness, injury, operation, treatment, hospital care during the last 5 years not mentioned above? Has any further care been recommended?	☐Yes ☐No	☐Yes ☐No	
78. Have you had any diagnostic test such as x-ray, electrocardiogram, blood test, pap smear, ultrasound, endoscopy, mammogram etc. (except pre-employment or annual checkup)?	☐Yes ☐No	☐Yes ☐No	
79. Have you been treated for alcohol or drug abuse during the last 5 years?	☐Yes ☐No	☐Yes ☐No	
80. Has your mother, father, brother or sister, had diabetes, breast/cervical/ovarian/colon or other cancer, high blood pressure, heart problem, stroke, hemochromatosis, Huntington's disease, polycystic kidney, multiple Sclerosis, or any other hereditary disease?	☐Yes ☐No	☐Yes ☐No	

If yes, please provide details below.

Family Member (Relationship to the Proposed Insured)	Condition / Illness (For cancer/heart disease, please specify type)	Age at Onset	Age at Death (if applicable)

81. IF PROPOSED INSURED IS UNDER 2 YEARS OLD: Was there any birth difficulty, RH problem, congenital or deformity such as deformed limbs, "blue baby", lack of mental development, or Down's Syndrome? ☐Yes ☐No

Additional Information (State the number of the field/question you are referring to)

Declaration on the Proposed Replacement of Existing Policies

1. Do you own any life insurance policy with any insurance company that is still in force, pending or for reinstatement?
☐ Yes (please provide details below) ☐ No

Owner/Payor or Proposed Insured	Insurance Company	Year Issued	Policy Status	Life Coverage	Critical Illness Coverage	Accident Coverage

2. Will you change or replace any life insurance policy/ies you own with the one you are applying for?
☐ Yes (Please submit Replacement Notification Form) ☐ No

3. Will you use policy loans, partial withdrawal, cash values, or surrender values from other life insurance policy/ies you own to pay for the one you are applying for? ☐ Yes (Please provide details and submit Replacement Notification Form) ☐ No	Insurance Company	Policy Number	Amount of Coverage

Reminders: We recommend that you RETAIN existing policies rather than replace them with new ones. If you replace your policy/ies, you may not be insurable on standard terms, your premiums may be higher because of age, or you may lose financial benefits earned over time.

We recommend you consult your present insurer before making a decision. Please compare carefully and decide what is best for you.

Declaration and Agreement

I confirm that my answers in this form and any extra forms attached are complete and true. I also understand and agree to the following:

1. My policy will start only upon payment of the first premium and on the effective date of the policy, which will be shown in my policy contract.
2. I agree to receive or access my policy contract, billing notice/s or any other corporate correspondence, documents or information pertaining to such policy electronically/digitally by making use of a computer, mobile or any digital device.

   I agree that the cost and expense to obtain and maintain or configure suitable software, device and/or equipment to receive or access such documents shall be borne by me.

   I agree and understand that transmission of information or communication over the Internet may be subject to interruption, transmission blackout and delayed transmission due to the Internet traffic, or incorrect data may be transmitted due to the public and open nature of the Internet or otherwise. The Company shall not be responsible or liable for any loss of accuracy or timeliness of any information or communication arising from the said reasons or in relation to any malfunctions in communication facilities that are out of control of the Company.

   I understand that within Manulife office hours and subject to Manulife's standard verification procedures, I can request for a printed copy of my policy contract for a fee.
3. I am not an undischarged bankrupt. I did not carry out any act of bankruptcy and there was no receiving or adjudication order in bankruptcy made or pending against me in the last 12 months.
4. I understand that if I designate an irrevocable beneficiary, I cannot make any changes under the policy that will adversely affect the ownership interests of the irrevocable beneficiary. These changes include, but are not limited to, making a partial/full withdrawal from the policy, taking out loans against the cash value of the policy, assigning or surrendering the policy, or even changing an irrevocable beneficiary, without the written consent of the irrevocable beneficiary/ies.
5. For the information I gave:
   - I am allowing the Company to keep them in line with their records retention policy;
   - I will inform the Company of any changes in them as soon as possible;
   - I will not hold the Company responsible for any claims, loss, liability and cost as a result of using them for valid purposes.
6. **DISCLOSURE:**
   In accordance with the Insurance Commission's Circular Letter No. 2016-54, as may be amended from time to time, your (Insured) medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.
7. The Company will buy units into my fund/s upon issuance of my policy. I am allowing the Company to deduct any bank transaction charges from my premiums before using them to buy units. (Applicable only to plans with variable life component).
8. The Company can correct this application through the "home office endorsement" section below to fix obvious mistakes and missing information.
9. The Company collects and uses my personal and sensitive information to operate an insurance business. By signing this form and continuing to avail of the Company's products and services, I agree that the information I provided (including the information of third parties) and any subsequent changes to it can be processed, shared, disclosed, transferred or used by the Company, including its shareholders, directors and employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group (including those located overseas), advisors, representatives, industry associations and databases, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels, and its third party service providers (whether within or outside the Philippines) within the rules set by the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's privacy policy available at www.manulife-chinabank.com.ph/Customer-Privacy-Policy for purposes of:
   - underwriting and approving my application;
   - administering, serving and reinsuring my policy;
   - marketing of products and services offered by the Company, any member of the Manulife Financial Group and those of its business partners; promoting, getting feedback on its products and services, and measuring client satisfaction;
   - conducting data analytics and doing automated data processing;
   - preventing money laundering or terrorist financing activities;
   - complying with reportorial and regulatory requirements of both local and foreign regulatory authorities (including local and foreign tax authorities and stock exchanges) as well as other legal, regulatory or contractual obligations of any member within the Manulife Financial Group, relating to information sharing, tax reporting or otherwise;
   - the Company's internal purposes such as governance, risk, actuarial, claims and underwriting management, and reporting; and
   - for other reasonable purposes related to the services provided.

10. 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.

11. I will not unreasonably cancel my consent which could result to the Company or any member of the Manulife Financial Group violating any law, rules, regulations or guidelines or its obligation under any contract or commitment with local or foreign regulators, governmental bodies or industry recognized bodies (whether within or outside the Philippines).

Signed at ______________________________ this ______ day of ____________________ , 20_____ .

____
Proposed Insured signature over printed name
(Signature is required if the Proposed Insured is 18 years old and above)

____
Owner/Payor signature over printed name
(If other than the Proposed Insured)

____
Signature of Authorized Signatory #1 (for Institutions) over printed name

____
Signature of Authorized Signatory #2 (for Institutions) over printed name

____
Financial Sales Associate (as witness) signature over printed name

____
Financial Sales Associate Code

Home Office Endorsement (For Manulife China Bank Use Only)

Authorization to Furnish Information

I am/We are allowing any licensed physician, medical practitioner, hospital, clinic or any other medically-related facility, insurance company, medical information database or any other public or private company, entity, government agency, individual, financial institutions or persons who has/have any of my/our records to give to MANULIFE CHINA BANK LIFE ASSURANCE CORPORATION and its reinsurer my/our information to verify my/our identity, to independently verify, the correctness of the collected data, authenticity of the identification, supporting documents, and any other information I/we submitted to Manulife China Bank Life Assurance Corporation as may be required by this insurance application. A photocopy of this authorization shall be considered valid as the original.

____
Proposed Insured's signature over printed name

____
Owner/Payor's signature over printed name

____
Date signed (mm/dd/yyyy)

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Financial Sales Associate's Report

What is your relationship with the Proposed Insured?

Do you know of anything, health-related or otherwise, that is not clear in this application form but can affect how it will be evaluated?

Identification Documents presented:

Minor Proposed Insured:
- ☐ Passport # ____
- ☐ School ID #* ____
- ☐ Birth Certificate ____
- ☐ Others, please specify: ____

*School ID must be signed by the school principal or head of the educational institution.

Adult Proposed Insured/Owner/Payor:
- ☐ TIN ____
- ☐ Phil. National ID # ____
- ☐ SSS / UMID / GSIS # ____
- ☐ PRC ID # ____
- ☐ Passport # ____
- ☐ Driver's License # ____
- ☐ Others, please specify: ____

For Foreign Nationals:
- ☐ ACR ID # ____
- ☐ Phil. National ID # ____
- ☐ Passport # ____
  with ☐ SIRV # ____
  or ☐ SRRV# ____

SIRV: Special Investor's Resident Visa
SRRV: Special Retirement Resident Visa

If Bank Referred, please indicate the following:

Employee # ____ Branch Code ____ Project Name (if applicable)
Employee Name ____ Branch Name ____ ____

By signing on this form, I declare that I have personally arranged and/or advised on this insurance application form; checked the identity of the Proposed Insured and/or Owner against the identification documents given above; reviewed the original copies of these identification documents, and any photocopy of these that are attached to this application is a true and faithful copy of the original; and interviewed the Proposed Insured and/or Owner before this application is submitted. AND, I certify to the best of my personal knowledge and based on official records, that the information provided above is true, correct and complete. I agree that I will submit a new report within five (5) business days if any certification on this report becomes incorrect.

Financial Sales Associate's signature over printed name ____ Financial Sales Associate Code ____ Date signed (mm/dd/yyyy) ____

APPLICATION NO. 1234567

Manulife China Bank
LIFE ASSURANCE CORPORATION

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Certificate of Temporary Cover

Name of Proposed Insured: ______________________________

The Proposed Insured will now enjoy a temporary insurance cover, subject to the conditions stated below:

How much is the insurance cover.

The temporary insurance cover is the amount of basic life and supplementary benefits you applied for. The total temporary insurance coverage (including other temporary covers on the Proposed Insured) will not be higher than PHP 1,000,000 or its US Dollar equivalent.

When the cover will start.

The temporary insurance cover will start when:
- the application is signed; and
- the first Medical Evidence Form (if required) is completed.

When the cover will end.

The temporary insurance cover will end:
- when the policy applied for has started (on the effective date of the policy);
- 60 days after the effective date of this certificate;
- 30 days after any identification documents we requested has not been submitted; or
- when the Proposed Insured dies.

APPLICATION NO. 1234567

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Replacement Notification Form

To be filled out ONLY if there are existing policies that this application will replace.

Customer Information

Name of Proposed Insured (Last, First, Middle)	Date of Birth (mm/dd/yyyy)	Home Address
Name of Owner, if other than the Proposed Insured (Last, First, Middle)	Date of Birth (mm/dd/yyyy)	Home Address

Existing Policies to be Replaced

Insured's Name (as it appears on the policy)	Company Name (as it appears on the policy)	Policy Number

I certify that I understand the nature of this change and hereby affix my signature below.

____
Proposed Insured's signature over printed name

____
Owner's signature over printed name

Note: The replacing insurer should furnish a copy of this form to the issuer of the policy being replaced within seven (7) days from the receipt of the application.

APPLICATION NO. 1234567

What the conditions are.

- This certificate must have the same application number and date as the application form.
- You have paid at least one monthly premium for the insurance cover applied for.
- Deposits made by check or draft must be payable to us, and must be honored by the bank for payment when it is first presented.
- The application form must be completed, signed, and submitted to us.
- The first Medical Evidence Form, if required, must be completed and submitted to us.
- The Proposed Insured must be in good health and a medically standard risk according to our underwriting guidelines.
- The Proposed Insured's age on his nearest birthday must not be more than 70.
- This certificate must be signed by the soliciting Financial Sales Associate.
- For products sold in tranches, this certificate will only be effective if the minimum tranche for the product is met. If this is not the case, we will return any premiums paid.
- If the coverage applied for will exceed Php1,000,000, we will refund the equivalent premium of the excess coverage.

If any of these conditions are not met, this certificate will not give any insurance cover and we will return any amount received without interest.

If the Proposed Insured commits suicide, the conditions in the Insurance Code will apply. If we will not pay a claim because of this, we will only return all premiums paid.

Financial Sales Associate's signature over printed name	FSA Code	Date (mm/dd/yyyy)	Place signed

Important Notice

No Financial Sales Associate has the authority to change the terms of your policy. If you do not receive your policy or any follow-up notice within three months, please let us know. The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws related to insurance and has supervision over insurance companies. It is ready at all times to assist the general public in matters pertaining to insurance. For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers +632-85238461 to 70 and email address pubassist@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph.