

Privacy Consent and MID Form

Manulife Chinabank Life Assurance Corporation
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Please answer completely and accurately and use black ink. This is considered as part of your application form.

PLAN DETAILS

Policy Number	Plan Name	Riders (if any)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Proposed Insured's Name		Date of Birth (MM/DD/YYYY)
<input type="text"/>		<input type="text"/> / <input type="text"/> / <input type="text"/>
Are you a citizen or a permanent resident of another country? If yes, please specify the countries:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any standing instructions to transfer funds to a foreign address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the countries:
Are you currently working or residing in another country? If yes, please specify the countries:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a Power of Attorney or signatory granted to someone with a foreign address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the countries:
Do you have a Beneficial Owner?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please accomplish the Beneficial Owner form.	Beneficial owner is any natural person who ultimately owns or control the owner and/or on whose behalf a transaction is being conducted

DECLARATION

- The company collects and uses my personal and sensitive information to operate an insurance business. By signing this application form and all the other forms attached to it, I agree that these information may be processed, shared, disclosed, transferred or used by the company for the following purposes in accordance with the Data Privacy Act of 2012, its implementing rules and regulations and our privacy policy available at www.manulife.com/Privacy-Policy:
 - underwriting and approving my application;
 - administering, servicing and reinsuring my policy;
 - securing my information;
 - marketing, promoting and getting feedback on our products and services;
 - measuring client satisfaction, profiling customers, and doing experience surveys;
 - doing automated data processing;
 - preventing money laundering or terrorist financing activities;
 - complying with any reportorial and regulatory requirements;
 - deciding on any insurance or related claim; and
 - for other purposes I consent to.
- Subject to the above limitations, I agree that the company's associated companies, business partners, affiliates, subsidiaries, advisors, representatives, industry associations and databases, local and foreign authorities and third party service providers (whether within or outside the Philippines) may also process, share, disclose, transfer or use my information.
- I will not unreasonably cancel my consent which could result to the company or any member of the Manulife 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).
- 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; and
 - I will not hold the company responsible for any claims, loss, liability and cost as a result of using them for valid purposes.

DISCLOSURE:

In accordance with the Insurance Commission's Circular Letter No. 2016-54, your 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.

SIGNATURES

Verified by:

Proposed Insured Signature over Printed Name

/ / _____
Date Signed (MM/DD/YYYY) Place Signed

Financial Sales Associate Signature over Printed Name

_____ **FSA Code**

/ / _____
Date Signed (MM/DD/YYYY) Place Signed