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| 1. General Information | | Name of Life Insured (Last, First, MI) | |
| Name of Policy Owner, if different from Life Insured, (Last, First, MI) | | Policy Number/s | |
| Telephone No. | Mobile No. | Email Address | |
| 2. Details of request | | | |
| Mode Change | | <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Sem-Annual <input type="checkbox"/> Annual | <i>Payment modes</i> <input type="checkbox"/> PDC <input type="checkbox"/> Auto-Debit Arrangement <input type="checkbox"/> Credit Card |
| Plan Change | | From _____ | To _____ |
| Face Amount Change | | From _____ <input type="checkbox"/> Increase <input type="checkbox"/> Decrease | To _____ |
| Policy Year Date | | From _____ | To _____ |
| Change/Addition of Scholar/Payor | | From _____ | To _____ |
| Dividend Option | | From <input type="checkbox"/> Accumulate with interest <input type="checkbox"/> Used to pay future premiums <input type="checkbox"/> Used to purchase Paid-up Additions <input type="checkbox"/> Paid in Cash | To <input type="checkbox"/> Accumulate with interest <input type="checkbox"/> Used to pay future premiums <input type="checkbox"/> Used to purchase Paid-up Additions <input type="checkbox"/> Paid in Cash |
| Premium Default option | | From <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-up insurance | To <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid-up insurance |
| Conversion of Term Plan/Rider | | The Conversion is <input type="checkbox"/> Partial _____ <input type="checkbox"/> Total _____ | The balance is <input type="checkbox"/> To be retained _____ <input type="checkbox"/> To be dropped _____ |
| Supplementary Benefit | | Supplementary benefit to be added/deleted/increased/decreased: _____ | |
| | | <input type="checkbox"/> Addition <input type="checkbox"/> Deletion <input type="checkbox"/> Increase _____ <input type="checkbox"/> Decrease _____ | |
| Adjustment of rating | | Reason _____ | |
| | | <input type="checkbox"/> Occupation <input type="checkbox"/> Health <input type="checkbox"/> Avocation _____ | |
| Update of Signatures | | 1. _____ | 2. _____ |
| Specimen signatures | | 3. _____ | |
| Others | | | |
| <p>Manulife agrees to this application for change. Hereafter, the above numbered policy will be deemed to have been changed as set out above upon proper imprinting of the President's facsimile signature. It is agreed that if any additions or amendments are made by the Company, acceptance by the Insured/Planholder or Payor/Owner of the changed or replacing policy to which a copy of this application for change, so amended, is attached, will ratify such addition or amendments.</p> <p>IF THE CHANGE IS SUCH THAT THE COMPANY REQUIRES EVIDENCE OF INSURABILITY, IT IS ALSO AGREED THAT:</p> <ol style="list-style-type: none"> The change will be incontestable after the change or replacing policy has been in force during the lifetime of Insured for two(2) years from the effective date of change, except for non-payment of premium or any other grounds recognized by law and jurisprudence. This incontestability period will not apply to supplementary contracts relating to benefits payable in the event of total disability and benefits which grant additional insurance specifically against death by accidental means. If the Life Insured commits suicide within one(1) year from effectivity of the policy change or of its last approved reinstatement, if any, the then pertinent provisions of the Insurance Code, as amended, will apply. Where suicide is not compensable, the liability of the Company is limited to the refund to the Beneficiary or Payor/Owner of the premiums actually received by the Company less all indebtedness under this policy. | | | |
| 3. Signatures | | Date signed | Place signed |
| | | Name and signature of Life Insured/Planholder | |
| Name and signature of Policyowner/Payor | | Name and signature of Collateral Assignee | |
| Name and signature of Irrevocable Beneficiary | | Name and signature of FSA/Witness | FSA's Code |

Manulife Chinabank Life Assurance Corporation

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