The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
Filinvest Corporate City, Alabang, 1781 Muntinlupa City
E-mail: headofc@insular.com.ph I Website: www.insularlife.com.ph
Tel.: (632) 8-582-1818 I Fax: (632) 8-771-1717 I VAT REG. TIN 000-464-124-000

WEALTH SERIES APPLICATION FOR RIDER ADDITION / CANCELLATION / AMENDMENT

Policy No:

1. INSURED

Prefix	Given Name	Surname	Suffix	Suffix Title

Occupation Details:

Occupation/Position:_____Employer/Company Name:_____
Describe nature of business: _____
Describe nature of work:_____
If OFW (please check) □ Seabased □ Landbased: Country of work_____

2. POLICY OWNER

Prefix	Given Name	Surname	Suffix	Suffix Title

3. Rider Addition/Cancellation/Amendment Options

SUPPLEMENTARY BENEFITS DESIRED	SUPPLEMENTARY BENEFITS TO BE CANCELLED	SUPPLEMENTARY BENEFITS TO BE AMENDED
□ Accidental Death Benefit Rider	□ Accidental Death Benefit Rider	□ HR FROM_____units TO_____units
□ Special Accident Rider	□ Special Accident Rider	□ HPR FROM_____units TO_____units
□ Special Accident Rider with Disability Indemnity	□ Special Accident Rider with Disability Indemnity	□ Others:_____
□ Others: _____	□ Others:_____	

4. For Policy Owner, average monthly Income from Employment/Businesses/Investments. P

5. UNDERWRITING INFORMATION (to be filled out for rider addition)

1. Have you ever sought consultation or advicefor health or medical reasons or been treated or confined in a hospital, sanitarium or similar institution?	□ YES □ NO	**DETAILS OF "Yes" ANSWERS (*Please identify question number and include dates, diagnosis, duration of illness, results of treatment or tests done, and name and addresses of all Attending Physicians and medical facilities. Use separate sheet, if necessary.)***
2. Have you ever been told you had: cancer or growth of any kind, diabetes, epilepsy, heart trouble, high blood pressure, tuberculosis, kidney disorder, mental/neurologic disorder or HIV-AIDS? If YES, please specify the ailment/impairment._____	□ YES □ NO	
3. Have you made any application for life, accident or sickness insurance or for reinstatement thereof which has been declined, postponed or modified in kind, amount or rate? If YES, please specifydetails. _____	□ YES □ NO	
4. Do you have other pending insurance applications with any other Company?	□ YES □ NO	
5. Have you ever engaged in or do you intend to engage in any car/motorcycle/motorboat racing, sky/scuba diving, and any other hazardous activities/sports/hobbies or make aerial flights as a pilot or crew member?	□ YES □ NO	
6. Do you intend to change residence or work abroad within the next 12 months?	□ YES □ NO	

I/WE HEREBY DECLARE AND AGREE THAT:

1. Each of the foregoing statements written is true and correct and that I/we have fully stated all exceptions to each of the statements. I/We agree that if no exceptions are listed in the blank space provided for such exceptions, it shall have the same force and effect as if the word "NONE" were written therein.
2. The addition/cancellation/amendment of rider/s will be effective on the next monthly policy anniversary after this application is approved by Insular Life.
3. The Insured must submit to Insular Life satisfactory evidence of insurability at my/our own expense.
4. The insurance charges will increase/decrease with the addition/deletion/amendment of riders.
5. The benefits provided by the amended/added rider/s cannot exceed the maximum risk that Insular Life can assume for the particular rider/s.
6. The rider charges will be based on the attained age of the insured.
7. The rider charges will be deducted from the fund value of the Policy every monthly policy anniversary.
8. The liability of Insular Life shall end on the monthly policy anniversary that the cancellation of the rider/s becomes effective.
9. Any additional rider coverage will be subject to the incontestability and suicide provision of the policy.
10. The regular premium remains the same unless an Application for Increase/Decrease in Regular Premium is submitted at the same time.

I/We understand that as a financial institution, Insular Life is subject to existing and future government regulations. I/We therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to anti-money laundering, tax monitoring and data privacy.

In this connection, I/we authorize Insular Life to process my/our personal and sensitive personal information including but not limited to its collection, use, retention, destruction or sharing with Insular Life subsidiaries, affiliates, agents, authorized third parties, and any medical information sharing facility for any legitimate purpose, including but not limited to underwriting and administration of insurance policies and insurance claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audit.

I/We also confirm that I/we have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

I/We hold Insular Life free and harmless from any liability that may arise from any collection, use, retention, destruction or sharing of said information as mentioned above.

Signed this_____ day of_____,_____at _____

POLICY OWNER	IRREVOCABLE BENEFICIARY	WITNESS/AGENT	ASSIGNEE/S
Printed Name and Signature	Printed Name and Signature	Printed Name and Signature	Printed Name and Signature

FOR HOME/FIELD OFFICE USE ONLY
Effective Date of Addition/Cancellation: _____

RECEIVED BY:_____**Office:**_____**Date:**_____**Secrets Number:**_____
Printed Name and Signature

Approved by:_____**Office:**_____**Date:**_____
Printed Name and Signature

HOME OFFICE ENDORSEMENT:

Do not detach this portion

No. _____

AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

In connection with my application for a life insurance policy with The Insular Life Assurance Co., Ltd. ("Insular Life") or with any matter relating to that insurance policy, if issued, I hereby authorize and request you or any physician, surgeon, hospital, clinic, insurance company, or other organizations to give Insular Life or its authorized representative, any and all information regarding my health, sickness or disease, injury, medical history, including any all records of my hospitalization, consultation, diagnosis, treatments which you/they may have acquired in attending to me in your/their professional capacity. A photocopy of this authorization shall be valid as the original.

Printed Name and Signature of Policy Owner

Printed Name and Signature of Insured