



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 | Website: www.insularlife.com.ph
 Tel.: (632) 8-582-1818 | Fax: (632) 8-771-1717 | VAT REG. TIN 000-464-124-000

REGULAR-PAY WEALTH SERIES APPLICATION FOR INCREASE/DECREASE IN REGULAR PREMIUM

Policy No:

1. INSURED				
Prefix	Given Name	Surname	Suffix	Suffix Title
2. POLICY OWNER				
Prefix	Given Name	Surname	Suffix	Suffix Title
3. INCREASE/DECREASE REGULAR PREMIUM				
From PhP		To PhP		
New Premium Direction desired				
Peso Fixed Income Fund		%		
Peso Balanced Fund		%		
Peso Equity Fund		%		
Others:				

I/WE HEREBY DECLARE AND AGREE THAT:

1. If the new regular premium results to an increase in sum insured, the insured must not have attained the maximum age indicated in the contract upon approval of this application.
2. The new regular premium must meet the minimum premium requirement of Insular Life.
3. The minimum amount by which I/we can increase my/our regular premium is subject to the guidelines set by the Company at the time of this application.
4. The new regular premium will be effective on the next premium due date after this application is approved by Insular Life. However, if there is an increase in sum insured, the increased regular premium will be effective on the next premium due date after my/our application for increase in sum insured is approved by Insular Life or the next premium due date after my/our acceptance of the non-standard terms is received by Insular Life.
5. The new regular premium will be invested according to the premium direction as indicated in this application or Application for Premium Redirection, whichever is in effect as of the approval date of this application.
6. If the sum insured is less than the new minimum guaranteed death benefit, we will apply for an increase in sum insured to equal the minimum guaranteed death benefit. Any application for increase in sum insured will be subject to underwriting requirements. If the application for increase in sum insured is not submitted within the thirty (30) days from the date this application is received by Insular Life, then this application will be considered a declined application.
7. When an increase in sum insured occurs, the insurance charges will likewise increase. If the increase in sum insured also applies to the supplementary contract, the charges for these supplementary contracts will also increase.
8. In case the increase in sum insured required with this application for increase in regular premium is approved under non-standard terms, I/we shall have the option of rejecting the offer. Insular Life shall then refund the amount deposited corresponding to the increase in regular premium. In such case, the increase in regular premium will not be approved by Insular Life.
9. If any required increase in sum insured is declined, the increase in regular premium will likewise be declined and Insular Life will refund the amount deposited corresponding to the increase in regular premium.

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 Printed Name and Signature	_____ IRREVOCABLE BENEFICIARY Printed Name and Signature	_____ WITNESS/AGENT Printed Name and Signature	_____ ASSIGNEE/S Printed Name and Signature
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FOR HOME OFFICE USE ONLY
 Effective Date of New Premium: _____

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

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

HOME OFFICE ENDORSEMENT: