The Insular Life Assurance Company, Ltd.
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Tel.: (632) 582-1818 | TIN 000-464-124 Non-VAT

Application for Removal/Reduction of Extra Premium on Account of Occupation

Policy Number:_____
Name of Policy Owner:_____ Name of Insured:_____

I hereby request for the removal/reduction of occupational extra premium. I represent and state the following:

1. That my occupation has been changed from_____ to _____ effective_____, and that I do not contemplate to make further change in my occupation. Hereunder are the details of my present occupation:

   Company/ Office where employed _____
   Address of Company/Office where employed _____
   Nature of Business _____
   Duties (describe in detail) _____

2. That my height is (_____cm) or (_____ft._____in) and my present weight is (_____kgs.) or (_____lbs.).

3. That I am of temperate habits and now in good health, free from all diseases, deformities and/ or ailments; that since the date of the last medical examination performed in connection with my policy, I have had no injuries, ailments or illness, and have not consulted or been prescribed for or attended to by a physician for any cause and that I have not been a patient or inmate of any hospital or institution.

   Exceptions to these statements are the following:

   _____
   _____
   _____

4. That each of the foregoing statement is true and correct and that I have fully stated all exceptions thereto; and that if within two years from date of approval of this application, any statement herein made shall be found to be untrue in any aspect, the Company shall have the right to re-impose the extra premium removed/ reduced by virtue of this application as from the date of such removal/ reduction.

Further, I understand that as a financial institution, Insular Life is subject to existing and future government regulations. I 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 authorize Insular Life to process my personal and sensitive personal information (also known as personally identifiable information or PII) including the collection, usage, storage, retention, and disclosure of my PII in the related processes and systems until its disposal. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents, medical information sharing facility of the insurance industry and third parties for any legitimate purpose, including the underwriting and administration of insurance coverage and claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audits, and such activities for which my PII may be required in fulfillment of mandated services across my entire life stages.

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 hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction or sharing of said information.

Done at _____this _____day of _____20_____.

_____
Signature over printed name of Insured

Conforme:

_____
Signature over printed name of Witness

_____
Signature over printed name of Policy Owner