VUL APPLICATION FOR TOP-UP

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 VAT REG. TIN 000-464-124-000

Policy No:

Instruction: Fill in all applicable spaces. Mark all appropriate boxes with an X.

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 you are a DESIGNATED NON-FINANCIAL BUSINESS AND PROFESSION, please check if: ☐ Business ☐ Profession
(if you are, please submit to us a Certificate of Registration (COR) from the Anti-Money Laundering Council (AMLC))
If Working Overseas (please check): ☐ Seabased ☐ Landbased Country of Work: _____
Source of Funds (select at least one): ☐ Business Income ☐ Family Income ☐ Income from Employment ☐ Savings ☐ Other: _____
Details on Source of Funds (Name of Business, Employer, etc): _____

2. POLICY OWNER

Prefix	Given Name	Surname	Suffix	Suffix Title

Occupation Details:

Occupation/Position: _____ Employer/Company Name: _____
Describe nature of business: _____ Describe nature of work: _____
If you are a DESIGNATED NON-FINANCIAL BUSINESS AND PROFESSION, please check if: ☐ Business ☐ Profession
(if you are, please submit to us a Certificate of Registration (COR) from the Anti-Money Laundering Council (AMLC))
If Working Overseas (please check): ☐ Seabased ☐ Landbased Country of Work: _____
Source of Funds (select at least one): ☐ Business Income ☐ Family Income ☐ Income from Employment ☐ Savings ☐ Other: _____
Details on Source of Funds (Name of Business, Employer, etc): _____

3. TOP-UP PREMIUM INFORMATION

Indicate Top-up Premium Direction: Plan Name:

FUND	PERCENTAGE	FUND	PERCENTAGE	FUND	PERCENTAGE
Balance Fund:	%	Select Equities Fund:	%	Dollar Fixed Income Fund:	%
Fixed Income Fund:	%	Guardian Fund:	%	Dollar Money Market Fund:	%
Equity Fund:	%	Peso Money Market Fund:	%	Others:	%
Growth Fund:	%	Own the New Economy (ONE) Fund:	%		%

Amount Deposited: ☐ PHP ☐ USD _____

Payment Options: ☐ Cash ☐ Check ☐ Credit Card Check No. _____ Bank

Official Receipt No.: _____
Date(mm/dd/yyyy): / /

4. For Policy Owner, average monthly Income from Employment/Businesses/Investments.	Applicant Owner	Proposed Insured
	PhP	PhP

5. UNDERWRITING INFORMATION OF THE INSURED

1. Have any of your Parents and/or siblings been diagnosed of any illness or medical condition/s? ☐ YES ☐ NO. If Yes, please give details on space provided.

Complete Name of Family Member	Relationship to Insured	Relationship to Policy Owner	Condition/Illness	Estimated Age at onset of Illness	Age and cause of Death (if applicable)

2. Build : Insured: Height: _____ cm or ___ ft ____ in Weight: _____ kgs or _____ lbs		**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.*)**
3. Have you ever sought consultation or advice for health or medical reasons or been treated or confined in a hospital, sanitarium or similar institution?	☐ YES ☐ NO	
4. 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	
5. 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 specify details. _____	☐ YES ☐ NO	
6. Do you have other pending insurance applications with any other Company?	☐ YES ☐ NO	
7. 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	
8. 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. Top-up can be made after policy issuance. If top up will result to an increase in sum insured, it can only be made subject to the Company guidelines on issue age limits.
3. The minimum top-up requirement is subject to company guidelines at the time of application.
4. Any increase in sum insured will be effective on the next monthly anniversary after this application is approved. If the new sum insured is approved under non-standard terms, the effective date will be the next monthly policy anniversary date after Insular Life receives my/our acceptance of the rating.
5. If Insular Life receives my/our application and top-up premium before the applicable cut-off time, the Company will use the unit price for that pricing date to buy units in my/our account/s. Otherwise, if received after the applicable cut-off time, the Company will use the unit price for the following pricing date. The Company has the sole discretion in determining the frequency of valuation, but said valuation will not be less frequent than weekly. The price for a particular pricing date will only be known at least one business day after the pricing date.
6. For top-up premium payments made through a soliciting agent, the date of the Official Receipt issued by Insular Life will govern, not the date of the Agent's Provisional Receipt.
7. For payments made through banks, and/or other authorized payment channels, either over-the-counter or online, any unmatched information in the deposit slip/payment slip/online transaction details may cause delay in premium allocation. The unit price prevailing at the time when premiums are properly applied becomes the applicable unit price.
8. The date that Insular Life receives the top-up premium is the latest of the following dates:

8.1. The official receipt date;
8.2. The date any non-local check or other form of payment is cleared;
8.3. The date Insular Life receives complete requirements; or
8.4. The date Insular Life receives my/our acceptance of the non-standard terms.

9. For Regular Pay VUL Plans:
   9.1. 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 aplication for increase in sum insured will be subject to underwriting requirements. If the application for increase in sum insured is not submitted within thirty (30) days from the date this application is received by Insular Life, then this application will be considered a declined application.
   9.2. when an increase in sum insured occurs, the insurance charges will likewise increase. If the increase in sum insured also applies to the supplementary contracts, the charge for these supplementary contracts will likewise increase.
10. Should I/we decide not to take-up this application under the revised terms offered by Insular Life, the amount refundable to me/us shall be the full amount deposited after it has been cleared.
11. If this application is declined, the amount refundable to me/us shall be the full amount deposited after it has been cleared.

DATA PRIVACY STATEMENT

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.

ANTI-FRAUD STATEMENT

FRAUD WARNING - It is unlawful for any person to (a) present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code, as amended.)

MEDICAL INFORMATION DATABASE STATEMENT

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.

CUSTOMER DUE DILIGENCE (CDD) REQUIREMENTS

During the effectivity of the policy, I hereby agree to the following:
1. In case Insular Life is unable to comply with the relevant CDD measures as required under Republic Act 9160 or the Anti-Money Laundering Act, as amended and relevant issuances due to my fault, Insular Life may apply the following:
   a. Measures to restrict the services available or prohibit any further transactions on the policy until full and proper CDD measures have been successfully conducted; and
   b. In case the foregoing is unsuccessful, terminate business relationship. The exercise of Insular Life of this measure shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable.
2. Be bound by the obligations set out in relevant United Nations Security Council Resolutions (UNCSR) relating to *the prevention and suppression of proliferation financing of Weapons of Mass Destruction (WMD)*, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA)[1]

Are you a US Person under US laws? ☐ YES ☐ NO

US Person means a) a US Citizen (including dual citizens where one country of citizenship is the US); b) US Permanent Resident; c) a person with substantial presence of more than 31 days in the current calendar year or a total of 183 days over the past 3 years from the current year; or d) a partnership/corporation organized in the US; e) US-owned foreign entity with 1 or more substantial US owner (one who owns more than 10% of the entity by vote or value).

If you are not a US Person under US laws, do you have any of the following US indicia? ☐ YES ☐ NO

a) US place of birth; b) current US residence address, mailing address, phone number associated with a financial account maintained in the US; c) a standing instruction to transfer funds to that account; d) a Power of Attorney or signatory authority granted to a person with a US address; or e) has an "in care of" address or "hold mail" address that is your sole address.

If you answered YES to any of the aforementioned questions, please accomplish the FATCA form to be provided by your Financial advisor/Broker/Agent.

DECLARATION

I/We declare that I/we have read the foregoing and agreed to the above statements and attest that my/our answers above are true and complete to the best of my/our knowledge. I/We understand that these acknowledgments and declarations shall be part of the processing and decision making of all my/our policy servicing transactions.

POLICYHOLDER Signature over Printed Name	INSURED Signature over Printed Name	WITNESS/AGENT Signature over Printed Name	ASSIGNEE/S Signature over Printed Name	PARENT/GUARDIAN Signature over Printed Name (If the Insured is below 18 years old)
DATE	DATE	DATE	DATE	DATE

[1]*(Instruction to Insular Life Customer Care Staff: If US Person or with US Indicia, please request Policyholder to accomplish the other required FATCA forms)*

FOR HOME/FIELD OFFICE USE ONLY

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

Policy 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 the Insured