



The Insular Life Assurance Company, Ltd.
 Insular Life Corporate Centre, Insular Life Drive
 Filinvest Corporate City, Alabang, 1781 Muntinlupa City
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 Tel.: (632) 8-582-1818 | VAT REG. TIN 000-464-124-000

REGULAR-PAY WEALTH SERIES APPLICATION FOR INCREASE/DECREASE IN SUM INSURED

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) <input type="checkbox"/> Seabased <input type="checkbox"/> Landbased: Country of work _____								
2. POLICY OWNER								
Prefix	Given Name	Surname	Suffix	Suffix Title				
3. INCREASE/DECREASE SUM INSURED								
From PhP _____			To PhP _____					
4. For Policy Owner, average monthly income from Employment/Businesses/Investments. ₱ _____								
5. UNDERWRITING INFORMATION (for Increase in Sum Insured)								
1. Average Monthly Income from Employment/Businesses/Investments. ₱ _____								
2. Have any of your Parents and/or siblings been diagnosed of any illness or medical condition/s? <input type="checkbox"/> YES <input type="checkbox"/> 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)			
3. 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.)					
4. Have you ever sought consultation or advice for health or medical reasons or been treated or confined in a hospital, sanitarium or similar institution?						<input type="checkbox"/> YES <input type="checkbox"/> NO		
5. 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.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
6. 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.						<input type="checkbox"/> YES <input type="checkbox"/> NO		
7. Do you have other pending insurance applications with any other Company?						<input type="checkbox"/> YES <input type="checkbox"/> NO		
8. 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?			<input type="checkbox"/> YES <input type="checkbox"/> NO					
9. Do you intend to change residence or work abroad within the next 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> 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. For increase in sum insured, the insured must not have attained the maximum age indicated in the contract upon approval of this application.
3. The insured must submit to Insular Life satisfactory evidence of insurability at my/our own expense.
4. The new sum insured will be effective on the next monthly policy anniversary date after this application is approved by Insular Life. 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 the increase in sum insured is the result of an increase in regular premium, the increased sum insured will be effective on the next premium due date after this application is approved or the next premium due date after my/our acceptance of the non-standard terms is received by InsularLife.
6. The reduced sum insured must not be less than the minimum coverage indicated in the contract.
7. The regular premium remains the same unless an Application for Increase/Decrease in Regular Premium is submitted at the same time.
8. The insurance charges increase/decrease with the increase/decrease in sum insured. If the increase in sum insured also applies to the supplementary contracts, the charges for these supplementary contracts will also increase.
9. The increase/decrease in sum insured can be done once every policy year or subject to the guidelines set by the Company at the time of this application.
10. The increase in sum insured will be subject to the Incontestability and Suicide provisions of the Policy.

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.

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/FIELD OFFICE USE ONLY

Effective Date of New Sum Insured: _____

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

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