



Authorization for Automatic Debit Arrangement (ADA) for Top-up Premiums

TO: INSULAR LIFE

I hereby authorize the periodic payment of Top-Up Premiums for the policy of _____
 (Relationship of Policy Owner to Bank Account Owner: _____). Name of Policy Owner

The following are the details of my request for ADA enrollment:

| | | | |
|---|-------------------------------|--------------------------|-------------------------|
| Policy Number _____ | Preferred Debiting Day _____ | Amount _____ | |
| Bank Account Number _____ | | | |
| Complete Bank Account Name/s _____ <small>(As it appears in relevant bank records)</small> | | | |
| Bank _____ | Branch _____ | | |
| Bank Account Owner's Name _____ | | | |
| <small>(PREFIX)</small> | <small>(GIVEN NAME)</small> | <small>(SURNAME)</small> | <small>(SUFFIX)</small> |
| Date of Birth _____ | Mother's Maiden Surname _____ | Contact Number _____ | |

By signing this form, I understand that:

1. I, as Bank Account Owner, authorize Insular Life and my bank to debit or cause the debiting from my enrolled bank account, the corresponding amount for payment of top-up premiums, as indicated above, for the enrolled policy.
2. For Joint Bank Accounts, I hereby understand, agree and represent that all transactions to be made by the undersigned in connection with ADA are done with full knowledge and consent of my co-depositor(s).
3. This payment facility allows the enrollment of the bank account of the Policy Owner, or his/her immediate family (i.e. spouse, children, grandparents, parents, parents-in-law, siblings).
4. In the event that, on debit date, Insular Life was not successful in debiting my enrolled bank account, Insular Life may initiate succeeding debit attempts against the same bank account, as it deems necessary and at its sole discretion.
5. I shall inform both Insular Life and my bank of my request for change/discontinuance of this arrangement. The change/discontinuance of my ADA enrollment shall take effect upon Insular Life's receipt of the notice of change or discontinuance.
6. Insular Life has the absolute authority to disapprove any application for ADA enrollment or cancel any ADA enrollment. In such event, I, the Bank Account Owner, will hold Insular Life free from any and all damages, liabilities, suits or causes of action, which I might directly or indirectly suffer, by reason of such disapproval or cancellation.
7. The Acknowledgment Receipt from Insular Life, which reflects the total amount debited due for the enrolled policy, shall serve as proof of payment.
8. 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.

Printed Name & Signature of Bank Account Owner

Date

I, the Policy Owner, accept and consent to the above arrangement.

Printed Name & Signature of Policy Owner

Date

For Office Use Only

Received by/Receiving Office/Date Received