

## Application for Addition of Rider (For Non-VUL Policies)

Policy Number: \_\_\_\_\_

Name of Policy Owner: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

I hereby apply for the addition of:

- |                                                          |                                                                           |
|----------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Waiver of Premium Benefit Rider | <input type="checkbox"/> Special Accident Rider with Disability Indemnity |
| <input type="checkbox"/> Accidental Death Benefit Rider  | <input type="checkbox"/> Others: _____                                    |
| <input type="checkbox"/> Special Accident Rider          |                                                                           |

to supplement and form part of my life insurance policy, and hereby make the following statements:

1. (a) Present occupation: State in detail the nature of your duties	(a)
(b) Company/Office where employed	(b)
(c) Address of Company/Office where employed	(c)
(d) Since when have you been so engaged?	(d)
(e) What was your former occupation?	(e)
2. Have you ever proposed to insure against Accident or Sickness? If so, give name of Company/ies	
3. (a) Are you now insured or proposing to insure Accident or Sickness? If so, in what Company/ies?	(a)
(b) Is this Proposal for additional insurance against Accident?	(b)
4. Have you ever been declined or accepted on special terms for Life, Accident or Sickness Insurance, or has any Company ever cancelled or refused to renew your Policy, or desired to amend the conditions or benefits? If so, what Company/ies and when?	
5. (a) Have you ever received compensation or payment of benefits out of any accident or health insurance you had taken? If so, by what company or companies?	(a)
(b) How much weekly benefit payment did you receive and for how many weeks?	(b)
6. (a) Is your sight now impaired, or have you ever had any affliction of the eyes? If so, since when?	(a)
(b) Is your hearing impaired, or have you suffered any complaint, or any discharge from the ear? If so, since when?	(b)

7. (a) Have you ever suffered from Spitting of Blood, Consumption, Tuberculosis, any Chest Disease or Lung Infection, Gout, Erysipelas, Rheumatic Fever, Rheumatism, Heart or Brain Disease, Paralysis, Asthma, a Fit of any Kind, Cancer, Diabetes, Appendicitis, any Disease of the Stomach or Intestines, or from any nervous or recurring disease? If so, since when?	(a)
(b) Have you any physical defect infirmity? If so, since when?	(b)
8. Give particulars of any Injury or Sickness for which you have received medical attention during the past five (5) years.	
9. For Women Only (a) Have you been menstruating regularly?	(a)
(b) When did you have your last menstruation?	(b)
(c) Are you pregnant?	(c)
(d) When was your last delivery?	(d)
10. Are there any circumstances connected with your occupation, health or habits of life, which render you especially liable to injury or sickness? If so, since when?	
11. What is your present height? _____cm or _____ft. _____inches and weight? ____kgs. or _____lbs.	

I hereby agree that, this application shall supplement and form part of my original application which was the basis of the said life insurance.

I further agree that, if within two years from date of approval of this Application any of the foregoing declarations and representations is found to be untrue in any respect, the The Insular Life Assurance Company, Ltd. (Insular Life) shall have the right to declare null and void any rider or certificate that it may have issued pursuant to said Application.

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.

I attach herewith the said policy together with a remittance of P\_\_\_\_\_ as deposit which may be applied to payment of the first premium upon approval of the application.

Done at \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_.

\_\_\_\_\_  
Signature over printed name of Insured

\_\_\_\_\_  
Signature over printed name of Policy Owner

\_\_\_\_\_  
Signature over printed name of Witness