



Ground Floor, LKG Tower, 6801 Ayala Avenue, 1226 Makati City
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APPLICATION FOR ADDITION OF RIDERS, REINSTATEMENT & ADJUSTMENT OF RATING

A. PLANHOLDER INFORMATION			
Family Name:	First Name:	Middle Name:	
Plan Number(s)	Occupation	Birthday (MM-DD-YYYY)	Age

B. TYPE OF REQUEST		
<input type="checkbox"/> ADDITION OF RIDER	NEW DATA <input type="checkbox"/> Term Insurance Amount: P _____ Effective Date: _____ <input type="checkbox"/> Others _____	REQUIREMENTS (1) Photocopy of current valid I.D. (2) Applicable underwriting requirements for the new owner. (3) Outstanding installment amount. (4) Processing fee, P _____
<input type="checkbox"/> REINSTATEMENT <input type="checkbox"/> Updating	<input type="checkbox"/> Redating	(1) Photocopy of current valid I.D. (2) Applicable underwriting requirements. (3) Pay outstanding installments. (4) Reinstatement fee, P _____
<input type="checkbox"/> ADJUSTMENT OF RATING <input type="checkbox"/> Occupation <input type="checkbox"/> Health <input type="checkbox"/> Avocation	<input type="checkbox"/> New Effective Date: <input type="checkbox"/> New Maturity Date:	(1) Photocopy of current valid I.D. (2) Applicable underwriting requirements. (3) Certification/Declaration of the change of occupation.

C. CONDITIONS:

Upon approval of this request, I hereby agree that the reinstatement/addition of rider/adjustment of rating of my Plan shall be subject to the following conditions:

- a) That the provision of contestability shall apply anew for one year from the approval date of plan change/reinstatement for all affected insurance coverages;
- b) That the plan change/reinstatement of my insurance coverage is based exclusively, on the statements of my health condition under letter D (Declarations and Representations), which I declare to be true and correct.

D. DECLARATIONS AND REPRESENTATIONS:

I hereby declare and represent to the best of my knowledge that:

- (a) I am not below 18 years old nor more than 65 years and 6 months old.
- (b) I have not been confined in any hospital, sanitarium or infirmary nor received medical or surgical treatment in the last twelve (12) months.
- (c) I have never had or been treated for heart condition, high blood pressure, blood disease, cancer, mass, tumor, abnormal bodily growth, diabetes, lung, kidney or stomach disorder or any other injury or physical impairment in the last five (5) years.
- (d) I am in good health and physical condition.
- (e) (For females only): I am not pregnant.

Note: If any of the above declarations and representations are not applicable to you, please give details below (specify dates, attending physician's name, hospital or clinic, diagnoses and treatment, etc.). Use separate sheet, if necessary.

(f) The total non-medical insurance coverage under this application and of any other application under this and other Group Insurance Policy covering other pre-need contracts/agreements issued by MANULIFE FINANCIAL PLANS in my name does not exceed the Non-Medical Limit set forth in the Group Insurance Master Policy issued by The Manufacturers Life Insurance Company (Philippines), Inc. to MANULIFE FINANCIAL PLANS.

Otherwise, I agree that the individual insurance under this and other Group Insurance Policy for these and other pre-need contracts/agreements in excess of the Non-Medical Limit will be without insurance coverage unless I undergo a medical examination and found acceptable in accordance with the underwriting rules prescribed by the aforementioned insurance company.

Plan type/s and count of previously issued contracts/agreements, if any:

I agree that the insurance coverage herein applied for is based on the truth of the foregoing declarations and is subject to the provisions of the Group Insurance Master Policy issued by The Manufacturers Life Insurance Company (Phils.), Inc. to MANULIFE FINANCIAL PLANS. I further agree that if the above is left blank or if there be any concealment, fraud or misrepresentation in the above statements material to the risk, the insurance company shall have the right to declare such insurance null and void, subject to the incontestability clause of the Group Insurance Master Policy.

I further agree that this application, including the declarations and answers given above, shall be the basis of the contract between MANULIFE FINANCIAL PLANS and myself, and shall be deemed part hereof.

I understand that if I am eligible, my insurance coverage shall take effect on the earlier date of either the Provisional Receipt or the Official Receipt of the initial installment for my education plan and term life rider, if any, provided I have signed the application form, have paid the corresponding installment due and was, in the opinion of the life company's authorized officers, insurable as a standard risk as of that date.

IN WITNESS WHEREOF, I have signed this application this ____ day of _____, 20____
at _____, Philippines.

<p>_____</p> <p>Planholder's Signature Over Printed Name</p>		<p>Planholder's Billing Address/Telephone No./Email Address:</p>		
PEPS/Witness Signature Over Printed Name:	PEPS Code:	Date Received:	Date Processed:	Date of Approval: