

Policy Details Change Form

In this form, "the Company" means the Manufacturers Life Insurance Co. (Phils.), Inc. "We", "us", "our", "I", "me" and "my" mean the Policyowner and/or the Life Insured as may be applicable.

General Information

Policy Number	Name of Policy Owner (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)	Email Address
Name of Life Insured (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)		Mobile Number (Country Code, Area Code, Telephone Number)
Current Office Address (Floor/No., Building/Street, Subdivision/Village, Barangay/District, Town/City, Province/State, Country, Zip Code) (for Institutional Policyowner)		

Policy Details to be Changed

Face Amount <input type="checkbox"/> Basic <input type="checkbox"/> Rider <input type="checkbox"/> Premium (for MAB Only)	From		
	To		
Supplemental Benefit <input type="checkbox"/> Add <input type="checkbox"/> Delete	Benefit		
	Coverage		
Supplemental Benefit Coverage: <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	Benefit		
	Coverage		
Premium Adjustment Due to change in:	Occupation	Avocation	Health/Medical Condition
Plan Change (Applicable for Traditional Policies only and within the first 6 months of plan effectivity.)	From		To
	From: Name of current Insurance Advisor (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)		
Insurance Advisor	To: Name of preferred Financial (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)		
	Reason:		
Premium Default Option <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> Extended Term Insurance <input type="checkbox"/> Reduced Paid Up	Change Status from Premium Paying To: <input type="checkbox"/> Reduced Paid Up <input type="checkbox"/> Extended Term Insurance		
Payment Mode <input type="checkbox"/> Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly	Change in Draw Date: _____ (Applicable to Auto-Debit Arrangement)		
Regular Payment Scheme <input type="checkbox"/> Credit Card <input type="checkbox"/> Auto-Debit Arrangement <input type="checkbox"/> Post-Dated Checks *Please submit additional forms and requirements to enroll policy to credit card, ADA or PDC			
Change in Dividend Option <input type="checkbox"/> Paid Up Addition <input type="checkbox"/> Pay Future Premiums <input type="checkbox"/> Leave on Deposit with Interest <input type="checkbox"/> Paid in Cash			

Declaration and Agreement

By signing this form and continuing to avail of the Company's products and services, I/we declare and agree that:

1. I/We agree to receive or access the policy contract, billing notice/s or any other corporate correspondence, documents or information pertaining to such policy electronically/digitally by making use of a computer, mobile or any digital device.
2. I/We agree that the cost and expense to obtain or configure suitable software, devices and/or equipment to receive or access such documents shall be borne by me/us.
3. I/We agree and understand that transmission of information or communication over the internet may be subject to interruption, transmission blackout and delayed transmission due to the internet traffic, or incorrect data may be transmitted due to public and open nature of the internet otherwise. The company, shall not be responsible or liable for any loss of accuracy or timeliness of any information or communication arising from the said reasons or in relation to any malfunctions in communication facilities that are out of control of the Company.
4. I/We understand that within Company office hours and subject to Manulife's standard verification procedures, I/we can request for a printed copy of the policy contract for a fee.
5. I/We allow the Company, including its affiliates, subsidiaries, service providers or any member of the Manulife Financial Group to process, collect, store, use, share or transfer all personal data I/we have provided for the purposes stated in the Company's customer Privacy Policy found in your website, <https://www.manulife.com.ph/Customer-Privacy-Policy>.
6. During the effectivity of the contract/policy, I agree to the following: in case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to my fault, the Company may apply the following: (a) measures to restrict the services available or prohibit any further transactions on the contract/policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.
7. I/we have read the above questions, statements and answers and certify that the information provided above is true, correct and complete based on my/our personal knowledge and official records. I/we also allow the Company to update my/our records based on the information found in this form and to use such to administer and service the policy. Once these changes are effected, I agree to receive a copy of the updated Policy Specifications to reflect the change requested in this form. If the change I/we requested requires evidence of insurability, I/we agree that the Company will not be able to challenge this policy change after two (2) years from the time it started. However, the Company can still challenge the policy change even after the 2-year period has ended for the following reasons:
 - a) the Company has not received payment for the policy's premium;
 - b) the account value of the variable life policy is not enough to pay the monthly deductions of the Company;
 - c) for any other reason allowed by law. If the Insured commits suicide within one (1) year from the change or the last reinstatement, the relevant Insurance Code provision will apply. If suicide is not covered, the Company will only pay the refund value.
8. If signing for the legal entity identified above, I/we certify that I/we have the capacity to sign for such legal entity.

Policyowner Signature Over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

Irrevocable Beneficiary/ies (if any) Signature over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

Assignee Signature Over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

Financial Advisor as Witness Signature over Printed Name

Date: _____ Place: _____ FA Code: _____
(mm/dd/yyyy)

Signature of Authorized Signatory #1 (for Institutions) over printed name

Date: _____ Place: _____
(mm/dd/yyyy)

Signature of Authorized Signatory #2 (for Institutions) over printed name

Date: _____ Place: _____
(mm/dd/yyyy)

For Manulife use Only

Valid IDs: Type: _____ ID# _____ ☐ Documents Presented: _____

Documents received and validated by: _____

Name of CSO

Branch

Date (mm/dd/yyyy)