

The Manufacturers Life Insurance Co. (Phils.), Inc.

Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229 Philippines

Customer Care: (02) 884-7000

Domestic Toll-Free: 1-800-1-888-6268

Website: www.manulife.com.ph

Email: phcustomer@manulife.com

Current Policy No.

New Policy No.

Please answer completely and accurately and in CAPITAL letters. Use black ink. Answer all fields, put "N/A" if not applicable. Any change should be counter-signed by Proposed Insured and/or Owner/Payor. In this form, "you" and "your" means the Proposed Insured and/or Owner/Payor as applicable. "We", "us", "our" and "the Company" means the Manufacturers Life Insurance Co. (Phils.).

CONVERSION DETAILS

1 Conversion is based on:

- Individual Term Policy
- Supplemental Term Benefit Provision
- Family Income Benefit Provision
- Group Term Policy (Please complete below)
 - (a) Employer or policyholder's full name _____
 - (b) Certificate number _____
 - (c) Date of termination of employment or membership _____
- Others _____

- 2 How much will be converted?:**
- Full Conversion
 - Partial Conversion (for selected products only)
 - Face Amount: _____
 - What happens to the current policy after conversion?
 - Retain
 - Drop

- 3 Conversion Age:**
- attained age
 - original age (for selected products only)

PROPOSED INSURED INFORMATION		OWNER / PAYOR INFORMATION <small>(To be filled out if Owner/Payor is different from Proposed Insured)</small>
		<p>³⁴Relationship to Proposed Insured _____</p> <p>If Fiancé/Fiancée, will there be legal marriage within the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Honorific	<p>⁴ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Others:</p>	<p>³⁵ <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Others:</p>
Last Name	⁵	³⁶
First Name (Suffix, if any)	⁶	³⁷
Middle Name	⁷	³⁸
Other Name/s (Alias/es, if any)	⁸	³⁹
Date of Birth	⁹ ____/____/____ <small>m m / d d / y y y y</small>	⁴⁰ ____/____/____ <small>m m / d d / y y y y</small>
City/Municipality of Birth	¹⁰	⁴¹
Country of Birth	¹¹	⁴²
Citizenship/Nationality (indicate all)	¹²	⁴³
Sex	¹³ <input type="checkbox"/> Male <input type="checkbox"/> Female	⁴⁴ <input type="checkbox"/> Male <input type="checkbox"/> Female
Civil Status	¹⁴ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> _____	⁴⁵ <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> _____
Contact Numbers (area code) phone number <input type="checkbox"/> I do not want to receive promotions via SMS.	¹⁵ Residence () Mobile ()	⁴⁶ Residence () Mobile ()
	Business () Overseas ()	Business () Overseas ()
Email Address <input type="checkbox"/> I do not want to receive billing notice and promotions via email.	¹⁶	⁴⁷ You will receive your billing notice via email
Present Address	¹⁷ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code	⁴⁸ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code
Permanent Address Same as present address? <input type="checkbox"/> Yes <input type="checkbox"/> No	¹⁸ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code	⁴⁹ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code
Business Address Same as present address? <input type="checkbox"/> Yes <input type="checkbox"/> No	¹⁹ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code	⁵⁰ _____ Floor/No., Building/Street, Subdivision / Village _____ Barangay/District, Town/City _____ Province/State, Country, Zip Code
Preferred Mailing Address	<input type="checkbox"/> Present Address <input type="checkbox"/> Permanent Address <input type="checkbox"/> Business Address	

PROPOSED INSURED INFORMATION		OWNER / PAYOR INFORMATION (To be filled out if Owner/Payor is different from Proposed Insured)		
Primary Occupation	²⁰ Title and/or functions	Tenure (# of Years)	⁵¹ Title and/or functions	Tenure (# of Years)
	Employer/Business Name	Nature of Business/Industry	Employer/Business Name	Nature of Business/Industry
Other Occupation (if any)	²¹		⁵²	
Source/s of Funds (check all that apply)	²² <input type="checkbox"/> Salary <input type="checkbox"/> Business <input type="checkbox"/> Gift / Inheritance <input type="checkbox"/> Savings <input type="checkbox"/> Sale of Asset <input type="checkbox"/> Remittance from <country> _____ <input type="checkbox"/> Others:		⁵³ <input type="checkbox"/> Salary <input type="checkbox"/> Business <input type="checkbox"/> Gift / Inheritance <input type="checkbox"/> Savings <input type="checkbox"/> Sale of Asset <input type="checkbox"/> Remittance from <country> _____ <input type="checkbox"/> Others:	
Estimated Gross Annual Income in PHP (including part time jobs)	²³		⁵⁴	
<input type="checkbox"/> SSS or <input type="checkbox"/> GSIS Number	²⁴		⁵⁵	
Tax Identification No. (TIN)	²⁵		⁵⁶	
For Foreign Nationals	²⁶ <input type="checkbox"/> ACR No. or <input type="checkbox"/> Passport No. _____ Expiration Date: _____		⁵⁷ <input type="checkbox"/> ACR No. or <input type="checkbox"/> Passport No. _____ Expiration Date: _____	
Are you a citizen or a permanent resident of another country?	²⁷ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:		⁵⁸ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:	
Are you currently working or residing in another country?	²⁸ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:		⁵⁹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:	
Do you have any standing instructions to transfer funds to a foreign account?	²⁹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:		⁶⁰ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:	
Do you have a Power of Attorney or signatory granted to someone with a foreign address?	³⁰ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:		⁶¹ <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify the country/ies:	
Will anyone other than the Proposed Insured and/or Owner/Payor be paying for this policy? If yes, complete appropriate questionnaire.	³¹ <input type="checkbox"/> Yes <input type="checkbox"/> No		⁶² <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you or any of your immediate family members or close relationships and associates been entrusted with prominent public position/s in (a) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (b) a foreign State; or (c) an international organization?	³² <input type="checkbox"/> Yes <input type="checkbox"/> No		⁶³ <input type="checkbox"/> Yes <input type="checkbox"/> No	

Does this policy have a Beneficial Owner? ³³ Yes No If yes, please accomplish the Beneficial Owner form. Beneficial owner is any natural person who ultimately owns or controls the owner and/or on whose behalf a transaction is being conducted.

NEW PLAN INFORMATION			
⁶⁴ Basic Plan	⁶⁵ Face Amount	⁶⁶ Mode of Payment <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	
⁶⁷ If Monthly, please choose payment scheme <input type="checkbox"/> Credit Card <input type="checkbox"/> Auto-debit Arrangement <input type="checkbox"/> Post-dated Check (PDC) Acknowledgement of PDC No. _____		⁶⁸ Initial Payment <input type="checkbox"/> Bank Transfer <input type="checkbox"/> Direct Deposit <input type="checkbox"/> Credit Card Amount _____ Date _____ PR No. _____ <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Others	

FOR VARIABLE LIFE ONLY	
⁶⁹ Details specific to funds with Income Payouts Income Payout Option <input type="checkbox"/> Cash <input type="checkbox"/> Reinvestment* If Cash, Payout Frequency <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly* *Default if no option is selected Preferred Start Date (MM/YYYY): _____	⁷⁰ Benefit Payout <input type="checkbox"/> Deposit to Account <input type="checkbox"/> Check <input type="checkbox"/> Peso <input type="checkbox"/> Dollar Bank: _____ Account Name: _____ Swift Code if USD: _____ Account No.: _____

FOR TRADITIONAL LIFE ONLY	
⁷¹ Dividend Option (for Participating Policies only) <input type="checkbox"/> Left to accumulate with interest <input type="checkbox"/> Used to purchase Paid-up Additions <input type="checkbox"/> Others <input type="checkbox"/> Used to pay future premiums <input type="checkbox"/> Paid in Cash (Note: Left to accumulate with interest will apply if no dividend option is selected)	⁷² What will happen to your policy if the premium is unpaid <input type="checkbox"/> Premium Loan Option <input type="checkbox"/> Reduced Paid-up Insurance <input type="checkbox"/> Surrender for Cash Value (Note: Reduced Paid-up Insurance will apply if no option is selected)

Enroll in ManulifeMOVE

*By providing my email address and purchasing an eligible plan and/or rider through this application, I, the Proposed Insured, agree that I am automatically enrolled in the ManulifeMOVE Program. Thus, upon issuance of my policy, I agree to receive the Terms and Conditions including other communications relating to the ManulifeMOVE Program through my email and mobile number.

I do not want to enroll in the ManulifeMOVE Program.

BENEFICIARIES

Name (Last Name, First Name M.I.)	% of Share	Citizenship/s	Relationship to Proposed Insured	Date of Birth (MM/DD/YYYY)	Country of Birth	Sex M / F	Type		Irrevocable	
							Primary / Contingent	Yes	No	
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Trustee if any beneficiary is below 18 years old: _____ NOTE: Beneficiary is Revocable unless specified
 Trustee's Date of Birth (MM/DD/YYYY): _____ Relationship of trustee to minor beneficiary/ies: _____

If the beneficiary is related as a Fiancée/Fiancé to the Proposed Insured, will there be legal marriage within the next 12 months? Yes No

DECLARATION ON THE PROPOSED REPLACEMENT OF EXISTING POLICIES

1 Do you own any insurance policy with any insurance company that is still in force, pending or for reinstatement?

Yes No If yes, provide details below.

Owner/Payor or Proposed Insured	Insurance Company	Life	Critical Illness	Accident	Policy Status	Year Issued

2 Will you change or replace any life insurance policy/ies you own with the one you are applying for?

If yes, please furnish details below and fill out the Replacement Notification Form. Yes No

3 Will you use policy loans or surrender values from other insurance policy/ies you own to pay for the one you are applying for? If yes, please furnish details below and fill out the Replacement Notification Form.

Yes No

Insurance Company	Policy Number	Amount of Coverage

REMINDEES: We recommend that you RETAIN existing policies rather than replace them with new ones.

- If you replace your policy/ies:
- You may not be insurable on standard terms;
 - Your premiums may be higher because of older age; or
 - You may lose financial benefits earned over time.

We recommend that you consult your present insurer before making a decision. Please compare carefully and decide what is best for you.

DECLARATION AND AGREEMENT

I confirm that my answers in this form and any extra forms attached are complete and true. I also understand and agree to the following:

- My new policy will start on the effective date indicated in the new policy contract. After conversion, the terms and conditions in the new policy contract will replace those in your current policy.
- I am not an undischarged bankrupt. I did not carry out any act of bankruptcy and there was no receiving or adjudication order in bankruptcy made or pending against me in the last 12 months.
- The company can correct this application through the "home office endorsement" section to fix obvious mistakes and missing information.
- The company collects and uses my personal and sensitive information to operate an insurance business. I understand that the company is a member company of the Manulife Financial Group and it may have obligations to meet the requirements of both local and foreign regulatory authorities (including local and foreign tax authorities such as the U.S. Internal Revenue Service) as well as other legal obligations from time to time relating to information sharing and tax reporting. By signing this application form and all the other forms attached to it, I agree that these information may be processed, shared, disclosed, transferred or used by the company for the following purposes in accordance with the Data Privacy Act of 2012, its implementing rules, as may be amended from time to time, and our privacy policy available at www.manulife.com/Privacy-Policy:
 - underwriting and approving my application;
 - administering, servicing and reinsuring my policy;
 - securing my information;
 - marketing, promoting and getting feedback on our products and services;
 - measuring client satisfaction, profiling customers, and doing experience surveys;
 - doing automated data processing;
 - preventing money laundering or terrorist financing activities;

- complying with any reportorial and regulatory requirements of any local and foreign regulatory and tax authorities;
- deciding on any insurance or related claim; and
- for other purposes I consent to.

Subject to the above limitations, I agree that the company's associated companies, business partners, affiliates, subsidiaries, advisors, representatives, industry associations and databases, local and foreign authorities and third party service providers (whether within or outside the Philippines) may also process, share, disclose, transfer or use my information.

- I will not unreasonably cancel my consent which could result to the company or any member of the Manulife Group violating any law, rules, regulations or guidelines or its obligation under any contract or commitment with local or foreign regulators, governmental bodies or industry recognized bodies (whether within or outside the Philippines).
- For the information I gave:
 - I am allowing the company to keep them in line with their records retention policy;
 - I will inform the company of any changes in them as soon as possible; and
 - I will not hold the company responsible for any claims, loss, liability and cost as a result of using them for valid purposes.

7. DISCLOSURE:
 In accordance with the Insurance Commission's Circular Letter No. 2016-54, as may be amended from time to time, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph.

- The company will buy units into my fund/s upon issuance of my policy (Applicable only to plans with variable life component).
- I am allowing the company to deduct any bank transaction charges from my premiums before using them to buy units.

Signed at _____
 this ____ day of _____, ____.

 Proposed Insured signature & printed name
(Signature is required if the Proposed Insured is 18 years old and above)

 Financial Advisor (as witness) signature & printed name / FA Code

 Owner/Payor signature & printed name (if other than the Proposed Insured)

 Irrevocable Beneficiary of current policy signature & printed name (if any)

 Assignee signature & printed name (if any)

 Authorized Signatory signature & printed name (for Institutions)

Special Requests:	Home Office Endorsement:
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