

Policy Details Change Form

General Information

Policy Number	Name of Life Insured (Last, First, Middle)		
Email Address	Mobile Number (Country Code, Area Code, Telephone Number)		

Policy Details to be Changed

Face Amount <input type="checkbox"/> Basic <input type="checkbox"/> Premium <input type="checkbox"/> Rider (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*	From		To

Premium Default Option**

- Premium Loan Option Surrender for Cash Value Reduced Paid-up Insurance

*Applicable within the first 6 months of plan effectivity.

**Applicable for traditional policies only.

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
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Regular Payment Scheme

- Credit Card Auto-Debit Arrangement Post-Dated Checks

*Manulife account must be enrolled in the accredited bank, additional forms and requirements must be submitted.

Change in Dividend Option

- Accumulative with Interest Reduced Paid-up Paid in Cash
 Pay Future Premiums Extend Term Insurance _____

Policy Details Change Form

Is the policy for reinstatement?

Yes No

If yes, submit accomplished Non-Medical form together with this Policy Details Change form

If yes, will anyone other than the Insured/Owner be paying for this policy?

Yes No

If yes, has the Insured/Owner or any direct relative of either person ever held a senior position in the government, political party, the military, any tribunal or government - owned corporation?

Yes No | Source of Income: _____ Estimated Net Worth: _____

Do you want to change your servicing Financial Advisor?

Yes No

If yes, provide the following details

Name of preferred Financial Advisor (Last, First, Middle)

Agent Code

Declaration and Agreement

By signing this form, I confirm that the information I provided is complete and true. I also allow Manulife to update my records based on the information in this form. Once these changes are affected, I agree to receive a copy of my updated Policy Specifications to reflect the changes I requested in this form. If the change I requested requires evidence of insurability, I agree that Manulife will not be able to challenge this policy change after two years from the time it started. However, we can still challenge it after this period has ended for the following reasons:

1. If we have not received payment for your policy's premium
2. If your account value is not enough to pay the monthly deductions (applicable to Variable Life only)
3. For any other reason allowed by law.

If the insured commits suicide within one year from the change or last reinstatement, the relevant Insurance Code provision will apply. If suicide is not covered, Manulife will only pay the refund value.

Policyowner Signature Over Printed Name

Date: _____ Place: _____

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

Date: _____ Place: _____

Assignee Signature Over Printed Name

Date: _____ Place: _____

Financial Advisor as Witness Signature over Printed Name

Date: _____ Place: _____ FA Code: _____

For Manulife use only

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

Documents received and validated by: _____
Name of CSO Branch Date (mm/dd/yyyy)