Manulife

**The Manufacturers Life Insurance Co. (Phils.), Inc.**
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 8888 6268
Website: www.manulife.com.ph
Email:phcustomercare@manulife.com

# Policy Details Change Form

In this form, "the Company" means the Manufacturers Life Insurance Co. (Phils.). "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 ☐ Do not know / not applicable) | Email Address |
|---|---|---|
| | | |

| Name of Life Insured (Last Name, First Name, Middle Name ☐ 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<br>☐ Basic<br>☐ Rider<br>☐ Premium (for MAB Only) | From | | |
| | To | | |
| Supplemental Benefit<br>☐ Add<br>☐ Delete | Benefit | | |
| | Coverage | | |
| Supplemental Benefit Coverage:<br>☐ Increase<br>☐ Decrease | Benefit | | |
| | Coverage | | |
| Premium Adjustment Due to Change in: | Occupation | Avocation | Health/Medical Condition |
| Plan Change* | From | | To |
| Insurance Advisor | From: Name of current Insurance Advisor (Last, First, Middle) | | |
| | To: Name of preferred Financial Advisor (Last, First, Middle) | | |
| | Reason: | | |

Premium Default Option**

☐ Automatic Premium Loan ☐ Extended Term Insurance ☐ Reduced Paid Up

*Applicable within the first 6 months of plan effectivity.
**Applicable for traditional policies only.

Payment Mode

☐ Annual ☐ Quarterly
☐ Semi-Annual ☐ Monthly

Change in Draw Date: _____

*Applicable to Auto-Debit Arrangement

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

☐ Paid Up Addition ☐ Pay Future Premiums
☐ Leave on Deposit with Interest ☐ Paid in Cash

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## Request for policy reinstatement options

☐ Straight Reinstatement ☐ Reinstatement thru Redating (applicable for traditional policy only)

1. Submit accomplished Non-Medical form together with this Policy Details Change form (for client age 60 and above, submit result of latest medical exam)
2. Is there any changes in your occupation? ☐ Yes ☐ No, If Yes state your current occupation _____
3. Will anyone other than the Insured/Owner be paying for this policy?
   ☐ Yes ☐ No, If Yes, please submit PIF form
4. 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?
   ☐ Yes ☐ No
5. Is the Owner a United States citizen, resident or a resident alien (US Green card holder)?
   ☐ Yes to any, please provide W-9 form ☐ No

   Does the Owner have a United States Taxpayer Identification Number (SSN/TIN), address and/or telephone number?
   ☐ Yes, please provide W8-BEN form ☐ No

   Or was the Owner born in the US and renounced his US Citizenship?

   ☐ Yes, please provide W8-BEN form and US Bureau of Consular Affairs' Certificate of Loss of Nationality in the US form ☐ No
6. Does this policy have a Beneficial Owner?
   ☐ Yes, please submit Beneficial Owner form ☐ No
7. Sources of Funds
   ☐ Salary ☐ Business ☐ Savings ☐ Remittances (country) _____ ☐ Others _____

   Estimated Net Worth _____ Estimated Annual Income _____

   (provide copy of proof or source of funds)

## 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 and maintain 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 the 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 Manulife 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 while I/we can can request for a copy of the billing notice/s or any other corporate correspondence at no charge through the Customer Case Hotline, or at any Manulife office.
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.

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6. During the efectivity 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 changed 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 suiced within one (1) year form 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.
   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)