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 1 888 6268
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Assignment Health Insurance

Please answer completely and accurately and use black ink. Please countersign on any corrections or erasures. In this form, "the Company" means The Manufacturers Life Insurance Co. (Phils.), Inc. "We", "us", "our", "I", "me" and "my" mean the Policy Owner, the Life Insured and/or the Assignee as may be applicable.

General Information

Policy Number	Name of Life Insured (Last Name, First Name, Middle Name ☐ Do not know / not applicable)

Name of Policy Owner (Last Name, First Name, Middle Name ☐ Do not know / not applicable)

Current Office Address (Floor/No., Building/Street, Subdivision/Village, Barangay/District, Town/City, Province/State, Country, Zip Code) (for Institutional Policyowner)

Email Address	Mobile Number (Country Code, Area Code, Telephone Number)

Assignee Information

For the value received, the Policy Owner hereby transfers and assigns to:

All rights and interests in the above policy are assigned by the Policy Owner to the Assignee as: (choose one)

☐ Absolute Assignment - Complete transfer of ownership of your health insurance policy to another person (Assignee) without any conditions.

☐ Contingent Owner - Also known as conditional transfer of your rights on your health insurance policy to the Assignee under certain terms and conditions.

Name of Assignee (Last Name, First Name, Middle Name ☐ Do not know / not applicable)			Relationship to insured
Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Contact Number	Email Address

Present Address (Floor/No., Building/Street, Subdivision/Village, Barangay/District, Town/City, Province/State, Country, Zip Code)

City of Birth	Country of Birth	Citizenship/s (Indicate all)	Nationality (if other than Citizenship)

Valid ID Type (For foreign nationals, please provide Passport or ACR#.)	ID Number	TIN

Source/s of Funds

☐ Salary ☐ Business ☐ Savings ☐ Remittance (Country): _____ ☐ Others: _____

Occupation	Tenure: ☐ Less than 2 years ☐ 2 to 5 years ☐ More than 5 but less than 10 years ☐ 10 years or more	Estimated Annual Income

Employer/Business Name	Nature of Industry

Other Information

1. Is the Owner a United States citizen, resident or a resident alien (US Green card holder)?
   ☐ Yes, to any, please provide W-9 form and skip question #2 ☐ No
2. Does the Owner have a United States Taxpayer Identification Number (SSN/TIN), address and/or telephone number?
   ☐ Yes, please provide W-8 Ben form ☐ No
3. If the Owner was born in the US, did the Owner renounce his/her US Citizenship? Skip if the owner is not born in the US.
   ☐ Yes, please provide W8-Ben form and US Bureau of Consular Affairs' Certificate of Loss of Nationality in the US Form
   ☐ No, please provide W9 Form with SSN
4. Will anyone other than the Owner be paying for this policy? ☐ Yes, please submit Payor Information Form ☐ No
5. 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
6. Does this policy have a Beneficial Owner (any natural person who directly or indirectly owns or control 20% or more of the shares of a legal entity; or ultimately owns/controls the customer and/or on whose behalf a transaction/activity is being conducted)?
   ☐ Yes, please submit Beneficial Owner Form ☐ No

Declaration and Agreement

I have read the above questions, statements and answers and I certify that the information provided above is true, correct and complete based on my personal knowledge and official records. If signing for the legal entity identified above, I certify that I have the capacity to sign for such legal entity.

I understand and agree that the Company collects and uses my personal and sensitive information to operate an insurance business. By signing this form, I agree that the information I provided (including the information of third parties) and any subsequent changes to it can be processed, shared, disclosed,transferred or used by the Company, including its employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group, advisors, representatives, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels and its third party service providers for purposes of administering and servicing my policy and for other purposes as stated in the Company's privacy policy and notice available at https://www.manulife.com.ph/Customer-Privacy-Policy, in accordance with the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's privacy policy and notice.

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.

_____
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)

For Manulife Use Only

Documents Presented: _____

Documents received and validated by: _____ _____ _____

CSO signature over printed name | Branch | Date (mm/dd/yyyy)

Please submit the following requirements:

Absolute assignment

1. Assignment Form
2. Beneficiary Form signed by the new policyowner
3. Photocopy of two (2) Valid IDs of old and new Policy owner
4. Acceptable Relationship of Assignee (in an Absolute Assignment) to Insured: legal spouse, common-law spouse, parent, child, fiance/fiancee, domestic partner, grandparent, grandchild. Relationships other than these should be justified and are subject to verification by the Company.

Contingent owner

1. Assignment Form
2. Photocopy of two (2) Valid IDs of old and new Policyowner

Notes:

If existing beneficiary/ies is/are IRREVOCABLE, the signature and the photocopy of two (2) valid IDs of such beneficiary are required. Additional requirements may still be required after the evaluation of your request.