

Beneficiary Change Form

Life Insurance Pension / Education
 Insurance Beneficiaries for Plans Pension Beneficiaries

In this form, "the Company" means the Manufacturers Life Insurance Co. (Phils.). "We", "us", "our", "I", "me" and "my" mean the Proposed Insured and/or Owner, Beneficiary, Legal Guardian, Trustee and/or Assignee as may be applicable.

Please answer completely and accurately and use black ink. Please countersign on any corrections or erasures. Please provide at least two valid IDs.

General Information

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

Please indicate all beneficiaries. They will supersede the beneficiaries you previously assigned to this policy. If you have previously designated beneficiaries as irrevocable, their signature is required in this form. If the space below is insufficient, please use the back portion of this form.

Beneficiary Information

Name <small>(Last Name, First Name), (Middle Name) <input type="checkbox"/> Do not know / not applicable</small>	Address <small>(Number, Street, Village, District, City/Municipality, State/Province, Country, Zip Code)</small>	Contact Mobile Number: <small>(Country Code) (Mobile No.)</small>	% of Share	The beneficiary is the Proposed Insured's <small>(state relationship):</small>	Date of Birth <small>(mm/dd/yyyy)</small>	Sex <small>(M / F)</small>	Citizenship/ Nationality <small>(indicate all)</small>	Place/Country of Birth	Irrevocable?	
									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"/>
Contingent Beneficiary (if any)									<input type="checkbox"/>	<input type="checkbox"/>
									<input type="checkbox"/>	<input type="checkbox"/>
									<input type="checkbox"/>	<input type="checkbox"/>

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

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Trustee Information (if beneficiary/ies are minors)

Name (Last Name, First Name, Middle Name, <input type="checkbox"/> Do not know/Not applicable)		Contact Number (Country Code)(Mobile No.)	The Trustee is the Minor Beneficiary's (state relationship):		
Address (Number, Street, Village, District, City/Municipality, State/Province, Country, Zip Code)		Citizenship/Nationality	Sex	Place/Country of Birth	Date of Birth(mm/dd/yyyy)

Declarations and Signatures

By signing on this form, I confirm that the information I provided is complete and true. I also allow the Company to update my records based on the information in this form. I understand that the beneficiaries listed in this form will replace any beneficiary I previously assigned to this policy. I fully understand that if I have designated my beneficiary/ies as irrevocable, I cannot exercise any of the options or transactions under this policy without the consent of the irrevocable beneficiaries. These options or transactions can be the following but not limited to, applying for loans, surrendering the policy for cash, changing policy details, and exercising other ownership rights under the policy. I also understand that in cases where an irrevocable beneficiary is a minor, I cannot exercise the same options under my policy without the consent of the minor's legal guardian. Legal guardian/s should be specifically authorized by court order or by law to act in behalf of the minor for the particular transaction.

The Company collects and uses my personal and sensitive information to operate an insurance business. By signing this form and continuing to avail of the Company's products and services, I agree that the information I provided and any subsequent changes to it (including the information of third parties) can be processed, shared, disclosed, transferred or used by the Company, including its shareholders, directors and employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group (including those located overseas), advisors, representatives, industry associations and databases, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels, and its third party service providers (whether within or outside the Philippines) within the rules set by the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's privacy policy available at www.manulife.com.ph/Customer-Privacy-Policy for purposes of:

- underwriting and approving my application;
- administering, serving and reinsuring my policy;
- marketing (including marketing of products and services offered by any member of the Manulife Financial Group and those of its business partners), promoting, getting feedback on its products and services, and measuring client satisfaction;
- conducting data analytics and doing automated data processing;
- preventing money laundering or terrorist financing activities;
- complying with reportorial and regulatory requirements of both local and foreign regulatory authorities (including local and foreign tax authorities and stock exchanges) as well as other legal, regulatory or contractual obligations of any member within the Manulife Financial Group, relating to information sharing, tax reporting or otherwise;
- the Company's internal purposes such as governance, risk, actuarial, claims and underwriting management, and reporting; and
- for other reasonable purposes related to the services provided.

During the effectivity of the contract/policy, I agree of 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

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. If signing for the legal entity identified above, I/we certify that I/we have the capacity to sign for such legal entity.

Signatures over Printed Names

_____ Policyowner	_____ Date Signed	_____ Place Signed	_____ Irrevocable Beneficiary (if any)
_____ Assignee (if any)	_____ Financial Advisor (as Witness)		
_____ Signature of Authorized Signatory #1 (for Institutions) over printed name		_____ Signature of Authorized Signatory #2 (for Institutions) over printed name	

Continuation of the list of beneficiaries from page 1 of this form. Please countersign to confirm the listed beneficiaries below.

Beneficiary Information

Name (Last Name, First Name), (Middle Name) <input type="checkbox"/> Do not know / not applicable	Address (Number, Street, Village, District, City/Municipality, State/Province, Country, Zip Code)	Contact Mobile Number: (Country Code) (Mobile No.)	% of Share	The beneficiary is the Proposed Insured's (state relationship):	Date of Birth (mm/dd/yyyy)	Sex (M / F)	Citizenship/ Nationality (indicate all)	Place/Country of Birth	Irrevocable?	
									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"/>
Contingent Beneficiary (if any)										
									<input type="checkbox"/>	<input type="checkbox"/>
									<input type="checkbox"/>	<input type="checkbox"/>

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

Trustee Information (if beneficiary/ies are minors)

Name (Last Name, First Name, Middle Name, <input type="checkbox"/> Do not know/Not applicable)	Contact Number (Country Code)(Mobile No.)	The Trustee is the Minor Beneficiary's (state relationship):			
Address (Number, Street, Village, District, City/Municipality, State/Province, Country, Zip Code)	Citizenship/Nationality	Sex	Place/Country of Birth	Date of Birth (mm/dd/yyyy)	

Signatures over Printed Names

Policyowner

Irrevocable Beneficiary (if any)

Assignee (if any)

For Manulife Use Only

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

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