

# Application for Fund Switch/Fund Allocation Change

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 Life Insured (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)	Name of Policyowner (Last Name, First Name, Middle Name <input type="checkbox"/> Do not know / not applicable)
Email Address		Mobile Number (Country Code, Area Code, Telephone Number)
Current Office Address (for Institutional client)		

## Fund Switch Details

Indicate the name of funds and the amount/percentage to be switched out the name of existing fund and name of new fund for switch in

Switch From		Switch To	
Name of Existing Fund	Percentage	Name of New Fund	Percentage
<b>Total</b>		<b>Total</b>	

Note: For funds with income payouts please fill out income payout form for GTIF/APPI/GPSI

## Fund Allocation Change (Effective on next premium)

Indicate the Name of funds and the percentage of the desired change of investment allocation of premium.

To (Name of New Fund)	Percentage
<b>Total</b>	

## Declaration and Agreement

By signing this form and continuing to avail of the Company's products and services, I/we declare and agree that:

- 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 devices.
- 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.
- I/We agree and understand that transmission of information over the internet may be subject to interruption, transmission blackout and delayed transmission due to internet traffic, or incorrect data may be transmitted due to the public and open nature of the internet or 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.
- 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 request for a copy of the billing notice/s or any other corporate correspondence at no charge through the Customer Care Hotline, or at any Manulife office.
- 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>.
- 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.
- 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.

\_\_\_\_\_  
 Policyowner Signature Over Printed Name

Date: \_\_\_\_\_ Place: \_\_\_\_\_

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

Date: \_\_\_\_\_ Place: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Authorized Signatory #1 (for Institutions) over printed name

\_\_\_\_\_  
 Signature of Authorized Signatory #2 (for Institutions) over printed name

\_\_\_\_\_  
 Financial Advisor as Witness Signature over Printed Name

Date: \_\_\_\_\_ 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)