



## BENEFICIARY INFORMATION FORM

**IMPORTANT NOTE: The following information are being requested in compliance with the requirements of the Anti-Money Laundering Council.**

### BENEFICIARY 1

GIVEN NAME		SURNAME		SUFFIX	
BENEFICIARY'S MOTHER'S MAIDEN NAME					
PREFERRED MAILING ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE			CONTACT INFORMATION (at least one)		
NUMBER & STREET			Landline No. Country Code ( ) Area Code ( ) Number ( )		
VILLAGE			Country Code ( ) Area Code ( ) Number ( )		
BARANGAY			Mobile No. Country Code ( ) Area Code ( ) Number ( )		
MUNICIPALITY/CITY			Country Code ( ) Area Code ( ) Number ( )		
PROVINCE			Fax No. Country Code ( ) Area Code ( ) Number ( )		
COUNTRY			Country Code ( ) Area Code ( ) Number ( )		
ZIP CODE			Email Address:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			*Civil Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> LS		Date of Birth (mm/dd/yy): <input type="text"/> / <input type="text"/> / <input type="text"/>
			Relation to Insured:		Designation: <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> I <input type="checkbox"/> C

### BENEFICIARY 2

GIVEN NAME		SURNAME		SUFFIX	
BENEFICIARY'S MOTHER'S MAIDEN NAME					
PREFERRED MAILING ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE			CONTACT INFORMATION (at least one)		
NUMBER & STREET			Landline No. Country Code ( ) Area Code ( ) Number ( )		
VILLAGE			Country Code ( ) Area Code ( ) Number ( )		
BARANGAY			Mobile No. Country Code ( ) Area Code ( ) Number ( )		
MUNICIPALITY/CITY			Country Code ( ) Area Code ( ) Number ( )		
PROVINCE			Fax No. Country Code ( ) Area Code ( ) Number ( )		
COUNTRY			Country Code ( ) Area Code ( ) Number ( )		
ZIP CODE			Email Address:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			*Civil Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> LS		Date of Birth (mm/dd/yy): <input type="text"/> / <input type="text"/> / <input type="text"/>
			Relation to Insured:		Designation: <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> I <input type="checkbox"/> C

### BENEFICIARY 3

GIVEN NAME		SURNAME		SUFFIX	
BENEFICIARY'S MOTHER'S MAIDEN NAME					
PREFERRED MAILING ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE			CONTACT INFORMATION (at least one)		
NUMBER & STREET			Landline No. Country Code ( ) Area Code ( ) Number ( )		
VILLAGE			Country Code ( ) Area Code ( ) Number ( )		
BARANGAY			Mobile No. Country Code ( ) Area Code ( ) Number ( )		
MUNICIPALITY/CITY			Country Code ( ) Area Code ( ) Number ( )		
PROVINCE			Fax No. Country Code ( ) Area Code ( ) Number ( )		
COUNTRY			Country Code ( ) Area Code ( ) Number ( )		
ZIP CODE			Email Address:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			*Civil Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> LS		Date of Birth (mm/dd/yy): <input type="text"/> / <input type="text"/> / <input type="text"/>
			Relation to Insured:		Designation: <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> I <input type="checkbox"/> C

### BENEFICIARY 4

GIVEN NAME		SURNAME		SUFFIX	
BENEFICIARY'S MOTHER'S MAIDEN NAME					
PREFERRED MAILING ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE			CONTACT INFORMATION (at least one)		
NUMBER & STREET			Landline No. Country Code ( ) Area Code ( ) Number ( )		
VILLAGE			Country Code ( ) Area Code ( ) Number ( )		
BARANGAY			Mobile No. Country Code ( ) Area Code ( ) Number ( )		
MUNICIPALITY/CITY			Country Code ( ) Area Code ( ) Number ( )		
PROVINCE			Fax No. Country Code ( ) Area Code ( ) Number ( )		
COUNTRY			Country Code ( ) Area Code ( ) Number ( )		
ZIP CODE			Email Address:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F
			*Civil Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> A <input type="checkbox"/> LS		Date of Birth (mm/dd/yy): <input type="text"/> / <input type="text"/> / <input type="text"/>
			Relation to Insured:		Designation: <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> I <input type="checkbox"/> C

POLICYHOLDER'S NAME & SIGNATURE				DATE	
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