Insular Life

The Insular Life Assurance Co., Ltd. Insular Life Corporate Centre
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WEALTH SERIES APPLICATION

No: __ __ Pre-assigned

Please fill in first two characters corresponding to plan code(e.g. V1, W1, V9)

Bar Code

1. PROPOSED INSURED				
Prefix	**Given Name**	**Surname**	**Suffix**	**Suffix Title**
2. APPLICANT OWNER				
Prefix	**Given Name**	**Surname**	**Suffix**	**Suffix Title**

3. Plan and Premium Direction

☐ **Peso Wealth Builder (V1)** ☐ **Peso Wealth Secure (W1)**		☐ **Dollar Wealth Builder(V9)**		☐ **Others:** ___________	
Fixed Income	%	Fixed Income	%		%
Equity Fund	%	Others:	%		%
Balanced Fund	%		%		%
Others: ________	%		%		%

Premium: ☐ **PhP** ☐ **USD** ______________

Additional Benefits *(please choose only those available for the plan)*

☐ Accidental Death Benefit ☐ Special Accident Rider ☐ Special Accident Rider with Disability Indemnity ☐ Others

Purpose of Insurance

☐ Personal/Family Protection	☐ Estate Conservation	☐ Others
☐ Keyman Insurance	☐ Educational Expenses	
☐ Creditor's Insurance	☐ Retirement Income	

Mode Premium Payment	☐ Annual	☐ Semi-Annual	☐ Quarterly

Details of Payment

Indicate Details of Payment:
Amount of Deposit_______________________
Agent's Provisional Receipt No. _______________ Official Receipt No. __________________
Agent's Provisional Receipt Date ______________ Official Receipt Date__________________

4. Beneficiaries

• The PRIMARY (P) beneficiary receives the death benefit in case of the prior death of the Insured. A PRIMARY beneficiary may be designated as REVOCABLE (R) or IRREVOCABLE (I) beneficiary. If the beneficiary designation is IRREVOCABLE, the Insured cannot change the beneficiary nor exercise any right under the policy without the consent of the irrevocably designated beneficiary. Unless otherwise stated, the primary beneficiaries shall share equally in the insurance proceeds.
• Should all the Primary beneficiaries die before the Insured, the CONTINGENT (C) beneficiary, if any, shall receive the death benefit. A Contingent beneficiary designation is always considered as revocable.
• If the Insured did not indicate the designation of his/her beneficiaries, default designation will be "Primary" and "Revocable".
• For minor beneficiaries, the representative of the minor beneficiary other than his/her parents, must secure and submit a court-approved Letter of Guardianship, including a Guardian's Bond when required by law.

Notes: *1) Use additional sheets for other beneficiaries, if necessary.* *2) CROSS OUT empty boxes below your last beneficiary entry.*

Complete Name	**Gender**	**Marital Status***	**Date of Birth** (mm/dd/ yyyy)	**Relation to Insured**	**Designation**		
	☐ M ☐ F	☐ S ☐ W ☐ LS ☐ M ☐ A	☐☐/☐☐/☐☐☐☐		☐ P	☐ R ☐ I	☐ C
	☐ M ☐ F	☐ S ☐ W ☐ LS ☐ M ☐ A	☐☐/☐☐/☐☐☐☐		☐ P	☐ R ☐ I	☐ C
	☐ M ☐ F	☐ S ☐ W ☐ LS ☐ M ☐ A	☐☐/☐☐/☐☐☐☐		☐ P	☐ R ☐ I	☐ C

**** Marital Status Legend – S(Single), M(Married), W(Widowed), A(Annulled), LS(Legally Separated)***

5. Underwriting Information (for the Proposed Insured only)

1. Average Monthly Income from Employment/Businesses/Investments. P______________________

2. Have any of your Parents and/or siblings been diagnosed of any illness or medical condition/s? ☐ YES ☐ NO. If Yes, please give details on space provided

Complete Name of Family Member	Relationship to Proposed Insured	Relationship to Applicant Owner	Condition/Illness	Estimated Age at onset of Illness	Age and cause of Death (if applicable)

3. Build : Proposed Insured: Height: _____ cm or ___ ft ____ in Weight: _____ kgs or ______ lbs		**DETAILS OF "Yes" ANSWERS (*Please identify question number and include dates, diagnosis, duration of illness, results of treatment or tests done, and name and addresses of all Attending Physicians and medical facilities. Use separate sheet, if necessary.*)**
4. Have you ever sought consultation or advice for health or medical reasons or been treated or confined in a hospital, sanitarium or similar institution?	☐ YES ☐ NO	
5. Have you ever been told you had: cancer or growth of any kind, diabetes, epilepsy, heart trouble, high blood pressure, tuberculosis, kidney disorder, mental/neurologic disorder or HIV-AIDS? If YES, please specify the ailment/impairment.______________________	☐ YES ☐ NO	
6. Have you made any application for life, accident or sickness insurance or for reinstatement thereof which has been declined, postponed or modified in kind, amount or rate? If YES, please specify details. ______________	☐ YES ☐ NO	
7. Do you have other pending insurance applications with any other Company?	☐ YES ☐ NO	
8. Have you ever engaged in or do you intend to engage in any car/motorcycle/motorboat racing, sky/scuba diving, and any other hazardous activities/sports/hobbies or make aerial flights as a pilot or crew member?	☐ YES ☐ NO	
9. Do you intend to change residence or work abroad within the next 12 months?	☐ YES ☐ NO	

No. __ __Pre-assigned

FOR HOME OFFICE USE ONLY
Approved by: ______________________________ Office: ______________________________________Date:__________________
HOME OFFICE ENDORSEMENT:

Declaration On The Proposed Replacement Of Existing Policy(ies) *- to be filled out by the Proposed Insured and/or Applicant Owner*

1. Total Life Insurance in Force on Proposed Insured and/or Applicant Owner *(Provide details below)*

	Insurance Company	Face Amount		Year of Issue
		Life	Dread Disease	
Proposed Insured				
Owner/ Payor				

2. State any pending life insurance application or reinstatement with any insurance company on the life of the Proposed Insured and/or Owner/Payor.

	Insurance Company	Face Amount		Year of Issue
		Life	Dread Disease	
Proposed Insured				
Owner/ Payor				

3. Has there been or will there be any change in existing insurance in force? ☐Yes ☐No
4. Will premiums for the insurance applied for be paid by a policy loan or surrender value from any existing policy? ☐Yes ☐No
(If yes to #3 & 4, please furnish details below)

Company	Policy Number	Date	Amount of Coverage

REMINDERS: It is usually disadvantageous to REPLACE existing life insurance policy/ies with a new one. By doing so,

- You may not be insurable on standard terms;
- You may have to pay a higher premium in view of your more senior age; or
- You may lose financial benefits accumulated over the years.

We would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

Declaration On The Proposed Replacement Of Existing Policy(ies) *- to be filled out by the Agent*

1. Is the policy applied for intended to change or replace any existing insurance inforce on the life of Proposed Insured ?
☐ Yes ☐ No

(If answered "Yes", please have the Proposed Insured and/or Owner/Payor complete the Replacement Notification form below)

2. Will the premiums for the insurance applied for be paid by a policy loan or surrender value from any previous policy in:
a) this company? ☐ Yes ☐ No
b) other company? ☐ Yes ☐ No

(If answered "Yes", please have the Proposed Insured and/or Owner/Payor complete the Replacement Notification form below)

I/WE HEREBY DECLARE AND AGREE THAT:

1. This insurance is issued based on the above answers and statements, which I/we represent to be true and complete to the best of my/our knowledge and belief.
2. The policy will not become effective until I/we have paid the entire first modal premium, and the policy delivered to me/us while the insured is in good health.
3. If Insular Life receives my/our application and premium from Tuesday of the previous week to Monday of the current week, the Company will use the price on Friday of the current week to buy units in my/our account/s. If Insular Life receives my/our application and premium from Tuesday of the current week to Monday of next week, the Company will use the price on Friday of next week to buy units in my/our account/s.
4. The date that Insular Life receives the premium is the later of the following dates:
   4.1. The official receipt date;
   4.2. The date any non-local check or other form of payment is cleared;
   4.3. The date the application is approved; or
   4.4. The date Insular Life receives my/our acceptance of the non-standard terms.
5. For premium payments made through a soliciting agent, the date of the Official Receipt issued by Insular Life will govern, not the date of the Agent's Provisional Receipt.
6. All charges will be deducted by selling the number of units equivalent to the amount of the charges as determined by Insular Life.
7. When the unit price is calculated, Insular Life will deduct from the fund an annual investment management charge at a rate to be disclosed by the Company, guaranteed not to exceed 2% per annum.
8. If this application is accepted and approved by Insular Life and the corresponding policy contract has been issued and I/we decide to return the policy within 15 days from the date of receipt of the policy contract and **provided no other transactions were made by me/us** from the time of application for insurance, then the amount refundable to me/us shall be the market value of the units plus insurance charges and initial or acquisition/administration charges.
9. If this application is declined, the amount refundable to me/us shall be the full amount deposited after it has been cleared.

Before signing below, I have read the above statements and answers and found them to be true and complete to the best of my knowledge. I agree that such statements and answers shall be part of the Application and are made to induce The Insular Life Assurance Co., Ltd. to issue the Policy contract applied for.

Signed this _____________ day of _______________________, ___________ at _______________________

WITNESS
Printed Name and Signature

APPLICANT-OWNER
Printed Name and Signature
(If other than Proposed Insured)

PROPOSED INSURED
Printed Name and Signature

SOLICITING AGENT
Printed Name and Signature

PARENT/GUARDIAN
Printed Name and Signature
(If the Proposed Insured is below 18 years old)

Left Thumbmark

Right Thumbmark

Do not detach this portion

No. __ ___Pre-assigned

AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

In connection with my application for a life insurance policy with The Insular Life Assurance Co., Ltd. ("Insular Life") or with any matter relating to that insurance policy, if issued, I hereby authorize and request you or any physician, surgeon, hospital, clinic, insurance company, or other organizations to give Insular Life or its authorized representative, any and all information regarding my health, sickness or disease, injury, medical history, including any all records of my hospitalization, consultation, diagnosis, treatments which you/they may have acquired in attending to me in your/their professional capacity. A photocopy of this authorization shall be valid as the original.

____ Printed Name and Signature of Payor/Applicant-Owner

____ Printed Name and Signature of the Proposed Insured

No. __ ___Pre-assigned

REPLACEMENT NOTIFICATION FORM		
Name of Proposed Insured	Date of birth(*mm/dd/yyyy*) ☐☐/☐☐/☐☐☐☐	Home Address
Name of Owner if other than Proposed Insured	Date of birth(*mm/dd/yyyy*) ☐☐/☐☐/☐☐☐☐	Home Address
EXISTING POLICIES TO BE REPLACED		
Insured's Name (as it appears on the policy)	Company Name (as it appears on the policy)	Policy Number

I certify that I understand the nature of this change and hereby affix my signature below _______________________________________ Signature over printed name of Owner / Date	(Note: The replacing insurer should furnish a copy of this form to the issuer of the policy being replaced within seven (7) days from the receipt of the application)

P R O X Y

No. __ ___Pre-assigned

Know All Men by These Presents: That I, the undersigned policyholder and member of the The Insular Life Assurance Company, Ltd., do hereby nominate, constitute and appoint the Proxy Committee (with the Executive Committee Chairman, the President and the Corporate Secretary, as members thereof), or any one of them if only one be present, or the Board Chairman, as my proxy to vote at any and all regular or special meetings of the members of The Insular Life Assurance Company, Ltd., and any adjournment thereof, as fully to all intents and purposes, as I might do if present and acting in person. In case of non-attendance of my above-named proxy at any particular meeting, I authorize and empower the Chairman of the Meeting to fully exercise all right as my proxy at such meeting. This proxy shall be valid and effective and continue to be so for a period of five 95) years from the time I become entitled to vote in accordance with the by-laws of The Insular Life Assurance Company, Ltd., as amended.

I understand that meetings of members may be regular or special, and shall be held at the place where the principal office of the Corporation is established or located. Regular meetings shall be held at 4:15 in the afternoon of the fourth Wednesday in May of each year, if such day be not a non-working holiday, otherwise, they shall be held on the first working day after such date. Special meetings may be held at any time by resolution of the Board of Trustees or when requested in writing by not less than one-fifth (1/5) of the members entitled to vote or by the Board Chairman, the Executive Committee Chairman, or the President (Article 3, Section3.5, By-Laws).

Signed this ___________________ day of ________________________________, ________, at _______________________________

Witness: ________________________________

____
Printed Name and Signature of Proposed Insured, or
Applicant-Owner if other than the Proposed Insured
(Please sign as your signature appears in your insurance applications)

Address:______________________________________
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