APPLICATION FOR LIFE INSURANCE

NON-GUARANTEED ACCEPTANCE ENDORSEMENT

Allianz PNB LIFE INSURANCE

Application No. _____

Please print clearly and completely blacken the circle. If possible, use black ink. Any change should be countersigned by the Proposed Insured and/or Applicant Owner.

A. PROPOSEDINSURED(PI)INFORMATION

(Please fill outApplicant Owner Information if the Owner/Payor is different from the Proposed Insured)

Beneficial owner refers to an individual who ultimately owns or controls the Applicant Owner and/or on whose behalf a transaction is being conducted.
If the Beneficial Owner/s is/are other than the Applicant Owner, please fill-out the **Beneficial Owner Supplementary form**.

1. Name (last name, first name, middle name) _____

Other Legal Name (last name, first name, middle name) _____

2. Date of Birth (mm/dd/yyyy) ___/___/___ 3. Gender ◯ Male ◯ Female

4. Place of Birth (city/mun, prov, country) _____

5. Civil Status ◯ Single ◯ Widowed ◯ Annulled ◯ Married ◯ Separated ◯ Divorced

6. Nationality _____ 7. Are you a U.S. Person?* ◯ Yes ◯ No

8. Mobile Number _____

9. Email _____ 10. Preferred Mailing Address ◯ Present ◯ Work

*(To be filled out if Proposed Insured is same as applicant owner. For YES, fill out the W-9 Form and the Consent and Waiver Form. Fill out the W-8 BEN form to certify that you are a non-U.S. person, If deemed as a non "U.S. Person")

11. Present Address

Unit/ Building Name | Lot/Block No. Street #/ Street Name | Barangay/Subdivision

_____

City/Municipality | Province | Country

_____

12. Work Information

Unit/ Building Name | Lot/Block No. Street #/ Street Name | Barangay/Subdivision

_____

City/Municipality | Province | Country

_____

Occupation (Title and/or Duties) _____ Estimated Annual Income _____

Employer / Nature of Business _____

13. Source of Funds ◯ Business ◯ Salary/ Commission ◯ Donations/ Contributions ◯ Remittances/Allowances/ Pension ◯ Investments ◯ Others _____

14. Are/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

B. INFORMATION ON BENEFICIARIES

(Please fill out and sign an additional Beneficiary Sheet if you have more than 3 beneficiaries)

The written CONSENT of ALL IRREVOCABLE beneficiaries will be required in all future transactions on the Policy. It is understood that the beneficiaries share equally unless indicated otherwise in the % share column.

IMPORTANT NOTE ON MINOR BENEFICIARIES:

According to Section 182 of the Revised Insurance Code, minors may exercise their rights (including receiving benefits and giving consent as irrevocable beneficiaries) under the insurance policy only through a Guardian. The parent/s, by default, are the minor's guardian. When the interest of the minor exceeds Five Hundred Thousand Pesos (PHP 500,000.00), the law further requires that a petition be filed in court for the posting of a guardian's bond.

BENEFICIARY 1

Name (last name, first name, middle name) _____

Date of Birth (mm/dd/yyyy) ___/___/___ Place of Birth _____

Nationality _____

Relationship of Beneficiary to Proposed Insured _____

Contact Information (Phone No. or E-mail) _____

Gender ◯ Male ◯ Female

Address Same as Present Address of ◯ Applicant Owner ◯ Proposed Insured

If not, indicate address _____

Primary ◯ %Share ____ % | Contingent ◯ %Share ____ %

Irrecovable ◯ Revocable ◯

BENEFICIARY 2

Name (last name, first name, middle name) _____

Date of Birth (mm/dd/yyyy) ___/___/___ Place of Birth _____

Nationality _____

Relationship of Beneficiary to Proposed Insured _____

Contact Information (Phone No. or E-mail) _____

Gender ◯ Male ◯ Female

Address Same as Present Address of ◯ Applicant Owner ◯ Proposed Insured

If not, indicate address _____

Primary ◯ %Share ____ % | Contingent ◯ %Share ____ %

Irrecovable ◯ Revocable ◯

9th Floor, PNB Makati Center, 6754 Ayala Avenue corner Legaspi St., Makati City, Philippines Tel. No. (632) 8818-LIFE (5433) / TIN 204-145-589-000

BENEFICIARY 3

Name (last name, first name, middle name)

Date of Birth (mm/dd/yyyy) / /

Place of Birth

Nationality

Relationship of Beneficiary to Proposed Insured

Contact Information (Phone No. or E-mail)

Gender ◯ Male ◯ Female

Address Same as Present Address of ◯ Applicant Owner ◯ Proposed Insured

If not, indicate address

Primary ◯ %Share ___ %

Contingent ◯ %Share ___ %

Irrecovable ◯ Revocable ◯

Total 100 % **Total** 100 %

C. INFORMATION ON THE POLICY APPLIED FOR

1. Plan Name

2. Sum Assured

3. Purpose of Insurance ◯ Income Continuation ◯ Estate Creation ◯ Mortgage ◯ Keyman Insurance ◯ Others _____

4. Payment Scheme ◯ Auto-Debit (Submit Auto Debit Forms. Initial Premium must be paid in Cash or Check) ◯ Cash/Check
◯ Credit Card (Submit Authorization for Continuous Billing Form) ◯ Others _____

D. PAYOUT OPTION FOR ALL LIVING BENEFITS

◯ **AUTOMATIC TRANSFER TO MY ACCOUNT** ◯ **CHECK** (to be mailed to my mailing address)

Fill-out only if payout option selected is "Automatic Transfer to My Account".

I hereby agree that all my living benefits (anticipated endowment proceeds net of outstanding loans, dividends, policy loans, withdrawals, surrenders and maturities) and refunds will automatically be transferred to my account with details indicated below, hereby granting **Allianz PNB Life Insurance, Inc.** authority to effect the same.

I fully understand and agree that the authorization shall be on a continuing basis and shall remain in full force and effect unless cancelled by the undersigned in writing or as determined by **Allianz PNB Life Insurance, Inc.**

By signing this application form, I agree to inform **Allianz PNB Life Insurance, Inc.** in writing of any change in the information provided or in my account status. I also authorize **Allianz PNB Life Insurance, Inc.** to deduct from the proceeds any applicable bank charge/s.

Bank Name

Bank Branch

Account Currency ◯ PHP ◯ USD Bank Account No.

If Joint Account, indicate the following: Type of Account ◯ AND ◯ OR ◯ AND/OR

Bank Account Name (please indicate the exact account name)

1.

2.

3.

E. DECLARATION ON THE PROPOSED REPLACEMENT OF EXISTING POLICY(IES)

Total Insurance Inforce on Proposed Insured

COMPANY	BASIC LIFE (indicate currency)	ACCIDENT (indicate currency)	YEAR OF ISSUE

Is the Policy applied for intended to change or replace any existing insurance in force on the life of Proposed Insured? ◯ Yes ◯ No

Will premiums for the insurance applied for be paid by a policy loan, withdrawal, or surrender from any existing policy? ◯ Yes ◯ No

(If yes, please furnish details below and accomplish the Replacement Notification Form)

COMPANY	POLICY NO.	AMOUNT OF INSURANCE BEING REPLACED (indicate currency)

REMINDER: It is usually disadvantageous to REPLACE existing life insurance policy(ies) with a new one. Some disadvantages are:

1) You may not be insurable on standard terms
2) You may have to pay a higher Premium in view of higher age
3) You may lose financial benefits.

Please note that in your own interest, 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 .

F. NON-MEDICAL QUESTIONS FOR PROPOSED INSURED

INSTRUCTIONS:

1) This section is for the Proposed Insured only.
2) For Applicant Owners applying for Payor's Benefit Rider (PBR), fill out the form "Non-Medical Question Form for Applicant Owner with PBR".

FAMILY HISTORY OF THE PROPOSED INSURED

DECLARATION

Please declare from the immediate family members *(father, mother, siblings)* who developed the following conditions on or before the age of 60.

Condition	Not Applicable	1 member	2 or more members
Cardiovascular Disease/ Coronary Artery Disease / Myocardial Infraction / Hypertension	◯	◯	◯
Cerebrovascular disease / Stroke	◯	◯	◯
Diabetes Mellitus	◯	◯	◯

Condition	Not Applicable	1 member	2 or more members
Alzheimer's / Parkinson's Disease	◯	◯	◯
Polycystic Kidney Disease	◯	◯	◯
Cancer: specify type _____	◯	◯	◯

BUILD

Height ⌊__⌋⌊__⌋ ft. ⌊__⌋⌊__⌋ in. or ⌊__⌋⌊__⌋⌊__⌋ cm. Weight ⌊__⌋⌊__⌋⌊__⌋⌊__⌋ lbs. or ⌊__⌋⌊__⌋⌊__⌋ kg.

Leave questions 1-6 blank if a Medical Examination Report is to be submitted within 7 days from application sign date

1. Have you ever been diagnosed or consulted with a medical doctor, or referred for medical tests or hospitalization for any kind of medical condition **beyond** the conditions listed below? • routine, pre-employment, pre-marriage, annual or physical, immigration and business permit purposes check-up with no **abnormality results** • normal child delivery, previous prenatal check-up with **no high risk pregnancy related condition** • Child Immunization / Child Monthly check up with **no serious findings** • wearing of glasses for short-sightedness, near-sightedness or astigmatism • full recovery from fever / colds / cough/ flu / sinusitis / upper respiratory tract infections **lasting for no more than a month** • successfully recovered from Tonsillectomy, Appendectomy, Cholecystectomy, Minor Bone fracture treatment or surgery **done more than twelve (12) months ago**.	◯ Yes ◯ No	If yes, please indicate the following and submit a copy of the medical report Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):
2. Have you ever been diagnosed or received treatment or medical advice for any **lump, cyst, cancer, high blood, heart** or **lung** disease, **diabetes, kidney** or **liver** disease, **mental** or **neurological** dysfunction, **pending or previous minor or major operation**, or any other ailment with or without physical impairment other than those listed in item number 1?	◯ Yes ◯ No	If yes, please indicate the following and submit the corresponding supplementary statement and a copy of the medical report Diagnosis/Reason: Date of first symptoms: Duration of illness: Doctor/Attending Physician: Other Details (including medication, treatment, test results, reoccurrence, current status, follow- up):
3. Do you smoke **more than** 30 sticks per day?	◯ Yes ◯ No	
4. Do you consume alcoholic beverages **more than** 6 bottles beer / 10 shots hard liquor / 4 glasses of wine per day?	◯ Yes ◯ No	
5. Except as prescribed by a physician, have you ever used habit forming drugs (cocaine, heroin, marijuana, LSD or amphetamines)?	◯ Yes ◯ No	If yes, please fill out the Drug Supplementary Statement.
6. For **women** only, are you pregnant? If yes, how many weeks?	◯ Yes ◯ No	

DECLARATIONS ON OCCUPATION/AVOCATION

1. Does the Applicant Owner expect to change:
   a) occupation? ◯ Yes ◯ No If yes, please specify occupation _____
   b) country of residence? ◯ Yes ◯ No If yes, please specify country _____
2. Does the Applicant Owner engage or intend to engage in any private flying, scuba, or skin diving; motorcycle, car, motorboat racing or any other extreme sports/hazardous activities? If yes, please specify activity/activities ◯ Yes ◯ No

_____

H. ACKNOWLEDGEMENT OF VARIABILITY APPLICABLE ONLY FOR PARTICIPATING LIFE INSURANCE POLICY

I hereby acknowledge the following:

1. I am applying for a participating life insurance with **Allianz PNB Life Insurance, Inc.**
2. I understand that a participating life insurance Applicant Owner is eligible to receive dividends, subject to the following limitations/conditions:
   a) **Allianz PNB Life Insurance, Inc.** in its sole discretion determines the amount of dividends, if any;
   b) Dividend rates will typically vary based on the performance of a number of factors including Allianz PNB Life Insurance, Inc.'s investment returns, mortality experience, expense and taxes;
   c) In view of the variability of dividend performance, it is not guaranteed:
      (i) that there will be accumulated dividends sufficient to offset any future premiums; or
      (ii) that the Policy will become self-liquidating (i.e., able to pay its own premiums) in the future.
3. That **Allianz PNB Life Insurance, Inc.** shall have the right to adopt or change the basis for any distribution of surplus and for the determ nation of any amount to be apportioned by way of dividend to said policy (if participating).

I. GENERAL DECLARATION

1. That these declarations with the answers to the above questions, shall be the basis of the Policy and form part of the same;
2. That Article 1250 of the Civil Code of the Philippines (Republic Act 386) relating to extraordinary inflation or deflation shall not apply in determining the extent of liability under the provisions of the Policy;
3. That I hereby warrant the eligibility of the beneficiary or beneficiaries named in this application, and further warrant that I shall not, in the future, designate any beneficiary who is ineligible under Articles 2021 and 739 of the Civil Code of the Philippines (Republic Act 386);
4. That should **Allianz PNB Life Insurance, Inc.** pay the proceeds of the Policy to an ineligible beneficiary, believing in good faith that said beneficiary is eligible, said payment shall free **Allianz PNB Life Insurance, Inc.** from liability under the Policy, if within sixty (60) days from the presentation by the ineligible beneficiary of the claim and proof of death of the Insured, no adverse claim is filed with **Allianz PNB Life Insurance, Inc.** by the person legally entitled to the proceeds of the policy;
5. That I hereby waive all provisions of law forbidding any physician, clinic, or other persons from disclosing or giving information or any record pertaining to any consultation, examination, attendance or treatment of the Proposed Insured and/or Applicant Owner, if Applicable;
6. That in accordance with the Insurance Commission's Circular Letter No. 2016-54, my information will be uploaded to a Medical Information Database, which includes medical and non-medical information, accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to My information in order to protect my right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph;
7. That If I accept delivery of the Policy and retain the same without objection within 15 (for Unit-Linked Plans) days from date of acceptance, such retention shall amount to an approval on my part of the insurance written therein and constitute a ratification by me, of any corrections or additions to this application imposed by **Allianz PNB Life Insurance, Inc.** in the space "For Home Office Use Only";
8. That I am not engaged in any of the unlawful activities listed in the Anti-Money Laundering Act of 2001 as amended and that I declare that the funds where premiums are sourced from, were not generated from any of the unlawful activities listed;
9. That during the effectivity of the policy, I agree that in case **Allianz PNB Life Insurance, Inc.** 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 the fault of the client, **Allianz PNB Life Insurance, Inc.** may apply the following: a) Measures to restrict the services available or prohibit any further transactions on the policy until full and proper CDD measures have been successfully conducted; b) In case the foregoing is unsuccessful, terminate business relationship. The exercise of **Allianz PNB Life Insurance, Inc.** of this measure shall only entitle the customer to receive the unused portions of premium or withdrawal value, if any, whichever is applicable;
10. That I am bound by obligations set out in the 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;
11. That if I decide to transact with **Allianz PNB Life Insurance, Inc.**, through electronic means, I agree to be solely responsible for the safekeeping of my password and/or other electronic identification, and shall hold **Allianz PNB Life Insurance, Inc.** free and harmless from any and all misuse of such password and/or electronic identification; and
12. I hereby expressly authorize **Allianz PNB Life Insurance, Inc.**, to obtain, collect, record, organize, store, update, modify, use, share, transfer, disclose, and/or destroy ("Process"), whether manually or via electronic channels, any and all information, including personal and sensitive information (Personal Data), about me, the life to be insured, my designated beneficiaries, and if applicable, the beneficial owner/s of my Policy for the following to;
    i. facilitate issuance of my Policy, process claims and other policy benefits , monitor and improve the quality of my Policy/ies and such services availed of by me, through programs including but not limited to offer of related products, customer satisfaction surveys, and statistical, actuarial and risk analyses;
    ii. comply with legal or regulatory obligations of Allianz PNB Life Insurance, Inc. under applicable local or foreign laws, rules and regulations relating to matters including but not limited to anti-money laundering, and tax monitoring/review/reporting.

    I shall inform Allianz PNB Life Insurance, Inc. of any changes relating to my Personal Data.

    ◯ I further authorize Allianz PNB Life Insurance, Inc. to share, transfer and/or disclose my information to any of its subsidiaries, affiliates, and partners for offer of related products and services.
13. I understand that my policy, including any endorsements, riders and other related documents (Policy), will be sent to me in electronic format. I also understand that Allianz PNB Life Insurance, Inc. shall communicate with me primarily via electronic channels, i.e. email, SMS, and mobile and web applications. This includes Premium Reminders, Renewal Notices, Reinstatement Notices, and other related documents. If I need a copy of my Policy, notices and other correspondence in paper form, I will contact Allianz PNB Life Insurance, Inc. by sending an e-mail to info@allianzpnblife.ph.

J. SIGNATURES

If a material fact is not disclosed in this application, any policy issued may not be valid. If in doubt as to whether a fact is material, you are advised to disclose it. This includes information that you may have provided to the Intermediary but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

I declare that all statements I have made are true, completely and correctly recorded to the best of my knowledge and belief.

_____	_____
Signature over Printed Name of Proposed Insured	Signed in the Philippines on Date (mm/dd/yyyy)
_____	
Signature over Printed Name of Applicant Owner, if other than Proposed Insured	

Application No. _____

INTERMEDIARY DECLARATIONS

A. DECLARATION ON THE PROPOSED REPLACEMENT OF EXISTING POLICY (IES)

Is the Policy applied for intended to change or replace any existing insurance in force on the life of Proposed Insured ◯ Yes ◯ No
(If yes, please furnish details below and accomplish the Replacement Notification Form)

Will premiums for the insurance applied for be paid by a policy loan, withdrawal, or surrender from any existing policy? ◯ Yes ◯ No
(If yes, please furnish details below and accomplish the Replacement Notification Form)

B. SIGNATURE

There are no known factors (health or otherwise) evident from the application form and that could affect the evaluation of the application. Furthermore, the identity of the Proposed Insured, Applicant Owner or Beneficiary is not any of the following:

- a Politically Exposed Person (PEP) or an immediate family member or a close associate of politically exposed person
- a remittance agent, money changer or foreign exchange dealer
- a member of Non Government Organization (NGO), Non-Profit Organization (NPO) or Foundation
- connected with a casino and related gaming entities
- a customs broker, a jewel / gem / precious metal dealer
- a gun/ ammunition / military equipment dealer
- a shell company
- from High Risk Jurisdictions/Countries that is recognized as having inadequate internationally accepted anti-money laundering standards; does not sufficiently regulate business to counteract money-laundering; fails to incorporate Financial Action Task Force (FATF) recommendation into its regulatory regimes
- from countries that exhibits a relatively high prevalence or risk of crime, corruption, or terrorist financing

Otherwise, Enhanced Due Diligence (EDD) form must be filled out and submitted.

I certify that I have verified the identity of the Proposed Insured and/or Applicant Owner. I have issued a Provisional Receipt to the Applicant Owner for the premium payment received, if applicable.

I have personally presented and explained the product and its benefits and have personally witnessed the Proposed Insured and /or Applicant Owner signing the application before the application is submitted.

Signature over Printed Name of Intermediary	Code	Signed in the Philippines on Date (mm/dd/yyyy)

C. REFERROR & REFERRING BRANCH DETAILS (FOR BANK CLIENTS)

Name of Referror _____
(last name, first name, middle name)

Referror's ID No. _____

Bank _____

Referring Branch _____

Signature of Referror _____ Date Signed (mm/dd/yyyy) ___/___/___

REPLACEMENT NOTIFICATION FORM

Allianz PNB LIFE INSURANCE

Proposed Insured (last name, first name, middle name) .....

Address ..... Date of Birth (mm/dd/yyyy) .....

Applicant Owner, if other than the insured (last name, first name, middle name) .....

Existing Policies to be replaced:

COMPANY (as it appears in the Policy Contract)	INSURED (as it appears in the Policy Contract)	POLICY NO.
.....	.....	.....
.....	.....	.....

I certify that I understand the nature of the change and hereby affix my signature below

.

Signature over Printed Name of Applicant Owner _____ Date _____

AUTHORIZATION TO FURNISH MEDICAL OR OTHER RELATED INFORMATION

Allianz PNB Life Insurance, Inc. is considering an application for insurance on my life and I hereby consent and authorize that:

1. Any physician, clinic, insurance company or other insurance industry association, institution or person that has any record of me and/or the proposed insured named in this application, may release or give to Allianz PNB Life Insurance, Inc. or its authorized representative, any and all information about me and/or the proposed insured named in this application;
2. Any information collected and held by Allianz PNB Life Insurance, Inc. may be released and/or disclosed to its affiliated companies and agents, other insurance companies and their affiliates and any medical information sharing facility of the insurance industry for any legitimate purpose, including but not limited to underwriting and administration of insurance coverage and claims;
3. I and/or the proposed insured named in this application, may be subjected to HIV testing for the purpose of underwriting this application or the coverage related to the insurance policy, if issued;
4. A personal investigation on me and/or the proposed insured named in this application be conducted by a duly authorized inspection agency which will provide any applicable information concerning my character, general reputation, personal characteristic, mode of living, health and financial status through personal interviews with friends, neighbors and associates.

A photocopy of this authorization shall be valid as the original. This authorization is in connection with my application for insurance only.

Signature over Printed Name of Proposed Insured _____ Signature over Printed Name of Witness _____ Date Signed _____

CERTIFICATE OF INTERIM COVERAGE

Allianz PNB LIFE INSURANCE

Allianz PNB Life Insurance, Inc. shall provide insurance coverage to the Proposed Insured if this certificate is signed and the following conditions are satisfied:

- The first acceptable modal premium has been paid with the Application for which a Provisional Receipt is issued, except worksite applications. For worksite applications, a valid authorization for premium deduction is submitted and received by the company together with the application; and
- All Underwriting requirements are fully complied with and the application is approved or would have been approved at standard rating based on existing underwriting guidelines of the company; and
- All required questions of the Application are answered completely and truthfully.

LIMITATION ON AMOUNT OF INSURANCE

The amount of benefits payable on the death of the life to be insured pursuant to this certificate is the amount which **Allianz PNB Life Insurance, Inc.** would have paid in accordance with the provisions of the insurance policy had it been issued but not to exceed PhP 2,000,000.00 in total when all amounts of benefits payable are converted to the Peso denomination using the prevailing exchange rate at the date of death of life to be insured, including any accidental death benefit, under all Certificate of Interim Coverages in force in respect of the deceased Insured. The benefits will be prorated among all Certificate of Interim Coverages in force on the same deceased Insured. Any amount paid for the amount of insurance in excess of **Allianz PNB Life Insurance, Inc.**'s liability under this certificate shall be returned to the Company.

TERMINATION OF COVERAGE ON THE LIFE INSURED WILL BE THE EARLIEST OF THE FOLLOWING:

1. The date a termination notice is sent by **Allianz PNB Life Insurance, Inc.** to the applicant;
2. The date a policy is issued and takes effect as a result of the Application ;
3. The date the application for insurance is cancelled as requested in writing by the applicant; and
4. The date of death of the Proposed Insured

Application No. _____

SPECIAL LIMITATIONS

- This Certificate does not provide benefits for dismemberment and/or disability.
- In cases of check payments, this Certificate will be invalid if check is not honored by the bank.
- No agent has the authority to modify the terms of this Certificate.
- SUICIDE: **Allianz PNB Life Insurance, Inc.** shall be liable only when it is committed after the policy has been in force for a period of at least two (2) years from the Policy Effectivity Date, or date of last reinstatement, if applicable, except if suicide is committed in a state of insanity, in which case suicide shall be compensable regardless of the date of commission.

BENEFICIARY: as stated in the Application

IMPORTANT NOTICE

The Insurance Commission, with offices in Manila, Cebu and Davao, is the government office in charge of the enforcement of all laws relating to insurance and has supervision over insurance companies. It is ready at all times to assist the general public in matters pertaining to insurance. For any inquiries or complaints, please contact the Public Assistance and Mediation Division (PAMD) of the Insurance Commission at 1071 United Nations Avenue, Manila with telephone numbers +632-5238461 to 70 and email address publicassistance@insurance.gov.ph. The official website of the Insurance Commission is www.insurance.gov.ph.

Signature over Printed Name of Applicant Owner	Signature over Printed Name of Proposed Insured

Attestation of the Intermediary

Name of Client (Applicant Owner):
Application No (Application):
Date and Mode of Remote Communication:

During my discussion with the Client, certify that:

1. I have personally presented and explained the product features and its benefits to the Client through remote means of communication.
2. I have explained to the Client in detail the results of the IRPQ as well as the investment risk of his/her chosen fund, the Sales Illustration, and the Financial Needs Analysis (applicable only for UL Products).
3. I have truly and accurately recorded all information provided by the Client in the Application Form under the Client's express consent and instruction.
4. I have performed the Know-Your-Customer and Client Due Diligence procedures as required under the Anti-Money Laundering Act and related laws and have verified the identity of the Proposed Insured and/or the Applicant Owner based on the identification documents presented.

_____ _____
Name of Intermediary Date

Attestation of the Client

Application No (Application):
Name of Product (Plan):
Date and Mode of Remote Communication:

I have discussed with _____ (Intermediary) through remote means of communication and attest and certify the following:
Name of Intermediary

1. That I intend to secure an insurance policy through the Intermediary who explained the features of the product and its benefits, illustrations, of the Plan including applicable riders to me.
2. That the details/declarations stated in the filled out Application Form are correct and based on the information and/or authentic documents provided by me. I personally filled out the application form and/or authorized the Intermediary to fill out the details of the Application Form on my behalf.
3. That I am currently in the Philippines and agree to be bound by the declarations in the said Application Form.
4. That I understand that the integrity and security of this email cannot be guaranteed over the internet, and that I will send email communications only to the correct official email address of my Intermediary.

Applicable only for UL Products:

5. That I fully understand that I will assume all investment risks associated with this Policy.
6. That I confirm that I have signified my consent and acknowledgment as needed in the Sales Illustration, Acknowledgment of Variability, and the Acknowledgment of Guaranteed Acceptance Program and that these shall form part of the insurance contract once issued.

_____ _____
Name of Applicant Owner Date