The Insular Life Assurance Company, Ltd.
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APPLICATION FOR GROUP INSURANCE PLAN

(Please send this back to Corporate Accounts Division)

Applicant: (Print in full)

(Surname)	(First Name, Suffix)	(Middle Name)

Age	**Sex** M ◯ F ◯	**For Female Applicant Only** Mother's Maiden Surname

Civil Status Single ◯ Married ◯ Widowed ◯ Annulled ◯ Legally Separated ◯ **Nationality**

EMPLOYER/UNION/ASSOCIATION	POSITION	DATE HIRED/MEMBERSHIP	DATE OF PERMANENT APPOINTMENT

	Present Address No./Street			**Permanent Address** No./Street		
Birthdate (mm/dd/yy)						
Birthplace	Brgy/Town/Municipality			Brgy/Town/Municipality		
	City/Province			City/Province		
Religion	Telephone No	Email Address	Zip Code	Telephone No	Email Address	Zip Code
	Cell phone No.			Cell phone No.		

1. DESIGNATION OF BENEFICIARIES:

- The **PRIMARY (P)** beneficiary receives the death benefit should the insured individual die ahead of him. A PRIMARY beneficiary may be designated as REVOCABLE or IRREVOCABLE beneficiary.
- If the beneficiary designation is **IRREVOCABLE (I)**, the insured individual cannot change the beneficiary nor exercise any right under the policy without the consent of the irrevocably designated beneficiary.
- If the primary beneficiary is designated as **REVOCABLE (R),** the insured individual may exercise all his rights under the policy without the consent of the revocably designated beneficiary.
- The **CONTINGENT (C)** beneficiary receives the death benefit should all the Primary beneficiaries die before the insured individual. A Contingent beneficiary designation is considered as revocable.
- If the insured individual fails to indicate the designation of his/her beneficiaries, default designation will be "Primary" and "Revocable".
- Unless otherwise stated, the primary beneficiaries shall share equally in the insurance proceeds.
- For minor beneficiaries, the representative of the minor beneficiary must secure and submit a court-approved Affidavit of Legal Guardianship.

Name of Beneficiaries (Surname, First Name, Middle Initial)	**Sex**	**Designation** *(Please read the notes above before ticking off the boxes below)*		**Relationship to the Insured**	**Birthdate** (mmddyy)	**Exact Amount/ Percentage of Sharing** (OPTIONAL)
		☐ P ☐ R ☐ I	☐ C			
		☐ P ☐ R ☐ I	☐ C			
		☐ P ☐ R ☐ I	☐ C			
		☐ P ☐ R ☐ I	☐ C			
		☐ P ☐ R ☐ I	☐ C			

2. IF PLAN PROVIDES DEPENDENT'S COVERAGE, PLEASE FILL OUT THE INFORMATION NEEDED BELOW.

GROUP INSURANCE WITH DEPENDENT'S COVERAGE

***Note:**

- If the Plan requires a hierarchy in enrollment of dependents, the highest in the hierarchy is reported as Dependent 1 below, followed by succeeding dependents in the same hierarchy
- Use additional sheets for other dependents, if necessary.
- In the absence of TIN, please indicate another identification number of your designated dependent. Any of the following may be used: SSS No., Passport ID No., Driver's License, Student No., or Member No. (if a member of a union/association/cooperative). Please identify beside the number the type of number indicated. Example 999-999-999 - SSS. No

DESIGNATION OF DEPENDENTS:

Name of Dependents *Prefix (e.g. Mr., Ms., Others), Given Name, Surname, Suffix (Jr./Sr.)*	Tax Identification No. (TIN) or other identification numbers	Gender	Date of Birth *(mm/dd/yyyy)*	Relation To Insured
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		
		☐ M ☐ F		

DECLARATIONS

A. DATA PRIVACY STATEMENT

I HEREBY CERTIFY that all the personal data contained herein are true and correct.

I also understand that as a financial institution, Insular Life is subject to existing and future government regulations. I therefore agree to be bound by all applicable domestic and international laws in relation to any matter including but not limited to the Data Privacy Act.

In this connection, I authorize Insular Life to process my personal and sensitive personal information including but not limited to its collection, use, disclosure or destruction. I likewise give my consent to Insular Life to share such information to its subsidiaries, affiliates, agents 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 and provision of any products, service or offers.

I hold Insular Life free and harmless from any liability that may arise from any collection, use, disclosure, destruction of said information.

B. BENEFICIARY DESIGNATION

I understand that in the absence of a designated beneficiary or if there is no surviving designated beneficiary at the time benefits will be paid out, Insular Life will pay to the following classes of beneficiaries, in this order of preference: surviving legitimate spouse; surviving legitimate, legitimated, and legally adopted children; surviving illegitimate children; surviving parents; surviving siblings of the full blood; surviving siblings of the half blood; or estate.

	_____	_____
Tax Identification Number or SSS No. or GSIS No.	**Applicant's Signature**	**Date Signed**

MEDICAL INFORMATION DATABASE - In accordance with the Insurance Commission's Circular Letter No, 2016-54, your medical information will be uploaded to a Medical Information Database 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 your information in order to protect your 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.

FRAUD WARNING - It is unlawful for any person to (a) present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and (b) fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any claim. Such acts shall be punishable by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court. (Section 251, Insurance Code, as amended.)

FOR HOME OFFICE USE ONLY

Policy Number _____ Certificate Number _____ Amount of Coverage _____