The Insular Life Assurance Company, Ltd.
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Authorization for Automatic Debit Arrangement (ADA) for Top-up Premiums

TO: INSULAR LIFE

I hereby authorize the periodic payment of Top-Up Premiums for the policy of ______________________________
(Relationship of Policy Owner to Bank Account Owner:________________). Name of Policy Owner

The following are the details of my request for ADA enrollment:

Policy Number ________________________ Preferred Debiting Day_______ Amount ______________

Bank Account Number ________________________

Complete Bank Account Name/s ____
(As it appears in relevant bank records)

Bank________________________________ Branch ________________________________

Bank Account Owner's Name ____
(PREFIX) (GIVEN NAME) (SURNAME) (SUFFIX)

Date of Birth_____________ Mother's Maiden Surname____________________ Contact Number ___________

By signing this form, I understand that:

1. I, as Bank Account Owner, authorize Insular Life and my bank to debit or cause the debiting from my enrolled bank account, the corresponding amount for payment of top-up premiums, as indicated above, for the enrolled policy.
2. For Joint Bank Accounts, I hereby understand, agree and represent that all transactions to be made by the undersigned in connection with ADA are done with full knowledge and consent of my co-depositor(s).
3. This payment facility allows the enrollment of the bank account of the Policy Owner, or his/her immediate family (i.e. spouse, children, grandparents, parents, parents-in-law, siblings).
4. In the event that, on debit date, Insular Life was not successful in debiting my enrolled bank account, Insular Life may initiate succeeding debit attempts against the same bank account, as it deems necessary and at its sole discretion.
5 I shall inform both Insular Life and my bank of my request for change/discontinuance of this arrangement. The change/discontinuance of my ADA enrollment shall take effect upon Insular Life's receipt of the notice of change or discontinuance.
6. Insular Life has the absolute authority to disapprove any application for ADA enrollment or cancel any ADA enrollment. In such event, I, the Bank Account Owner, will hold Insular Life free from any and all damages, liabilities, suits or causes of action, which I might directly or indirectly suffer, by reason of such disapproval or cancellation.
7. The Acknowledgment Receipt from Insular Life, which reflects the total amount debited due for the enrolled policy, shall serve as proof of payment.
8. I 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 anti-money laundering, tax monitoring and data privacy.

   In this connection, I authorize Insular Life to process my personal and sensitive personal information including but not limited to its collection, use, retention, destruction or sharing with Insular Life subsidiaries, affiliates, agents, authorized third parties, and any medical information sharing facility for any legitimate purpose, including but not limited to underwriting and administration of insurance policies and insurance claims, marketing and promotion of products, market research, data analytics and automated processing systems, internal and external audit.

   I also confirm that I have sought the consent of the insured and/or the beneficiary/ies in sharing his/her personal and sensitive personal information, as may be applicable.

   I hold Insular Life free and harmless from any liability that may arise from any collection, use, retention, destruction or sharing of said information as mentioned above.

____ ______________
Printed Name & Signature of Bank Account Owner Date

I, the Policy Owner, accept and consent to the above arrangement.

____ ______________
Printed Name & Signature of Policy Owner Date

For Office Use Only

Received by/Receiving Office/Date Received