No. _____

PhilLife Financial Assurance Corporation
11/F STI Holdings Center, 6764 Ayala Ave., Makati City
Tel. No. (632) 7798-54-33
TIN 007-884-680-000

INDIVIDUAL APPLICATION FORM
Agent's Loyalty Plan (for Group Insurance)

Policyholder	**Philippine Life Financial Assurance Corporation (PhilLife Financial)**						
Name of Insured / Agent (Last Name, First Name Middle Name)							
Address							
Nationality		**Civil Status**		**Gender**		**Tel. No.**	
Place of Birth		**Birth Date**		**Height** (ft. & in.)		**Weight** (lbs)	
Tel No./Cellphone No.		**Office No.**		**Email Address**			
TIN		**SSS/GSIS**		**Source of Income**			
Occupation *(other than as agent)*				**Place of Work**			

Plan: Loyalty Plan	**No. of Units:**	**Premiums** (See Schedule):

ANNUAL PREMIUM (AP) SCHEDULE

	Age	18 – 64			65 - 85
	Number of Units	1	2	3	1
	Benefits	100,000.00	200,000.00	300,000.00	50,000.00
(A)	Annual Premium	300.00	600.00	900.00	300.00
(B)	Extra Premium				
(C)	Gross Annual Premium (GAP) = (A)+(B)	300.00	600.00	900.00	300.00

Name(s) of Beneficiary(ies)	DOB	Relationship to Insured

STATEMENT OF GOOD HEALTH

	Checkbox Yes	Checkbox No	
1. Are you presently in good health and entirely free from any mental or physical impairments or deformities?	☐	☐	If you answered "No" to the question, please give complete details (including dates, duration and treatment, names and addresses of physician's clinics/hospitals). Use reverse page.

AUTHORITY TO DEDUCT (ATD)

Request for Evaluation of ATD

1. By signing this Form, the undersigned Agent authorizes PhilLife to charge against his/her Agent's Compensation the Annual Premium/s for the first year of the Agent's PhilLife Loyalty Plan purchased, and for the subsequent renewal years, unless the coverage is modified, or the authorization is expressly revoked, or the Master Policy is terminated, or the Agent's contract with PhilLife is terminated. Further, this continuing authorization shall be in effect provided: he/she has an active license with PhilLife.
2. Agent's compensation is understood to mean as the Agent's commissions, service fee, overrides and production bonus, and earned fidelity fund.
3. Agent authorizes PhilLife to share this Form and its attachments with PhilLife's officers and staff involved in the processing of the insurance and the transactions specified herein.
4. PhiLife commits that it adheres to the terms and conditions outlined in this Form and shall ensure that the coverage and deducted amounts are accurately allocated and recorded under the relevant transaction stated in this Form.
5. The Agent and PhilLife understand that they must maintain strict confidentiality regarding deductions and comply with data protection and privacy regulations.
6. The Agent has read the conditions of this Form and the product description and authorizes the company's Agency Accounting Department to evaluate whether the compensation can accommodate a deduction for the GAP corresponding to the No. of Units written above. When allowable, the Agent authorizes the Company to deduct from the Agent's compensation the GAP indicated above and to apply the same as premium for the Loyalty Plan. The Agent understands that the COC shall be inforce while this ATD is in effect.
7. The Agent hereby applies for group insurance and certifies that the foregoing statements and answers are full, complete and true, and agrees that they shall be the basis of the insurance under the Group Policy. The Agent authorizes any physician, nurse, hospital, clinic, or any other insurance company or organization to disclose to PhilLife or its authorized employee or representative any and all information regarding the Agent's medical history/medical records/investigation reports in connection with this Application. Further, the Agent authorizes PhilLife to process and retain the foregoing statements and answers in accordance with R.A. No. 10173, the Data Privacy Act of 2012, R.A. No. 9510, the Credit Information System Act, and IC Circular Letter No. 2016-54, Medical Information Database. PhilLife shall not be liable for any claim on account of illness, injury or death, the cause of which was known to the Agent prior to approval of the Agent Application for insurance and withheld or concealed in the above statements.
8. The Agent fully understands and agrees to the terms and conditions of this group insurance.

Date applied: _____ Place: _____

Signature over printed name of the Agent:

_____ _____
[Name] Agent Code

ENDORSEMENT BY THE IMMEDIATE MANAGER

The undersigned recommends the named agent herein for enrollment to the Agent's Loyalty Plan.

_____ _____
Sales Director Marketing Director
Signature over Printed Name Signature over Printed Name

<u>* FOR HEAD OFFICE USE ONLY ***</u>**

<u>GAP EVALUATION</u>

Licensing Remarks

Agent Status: ___ Active ___ Inactive

_____
JISELINE MAY ESTELLORE – Licensing Analyst

Application & Billing Approval

Application Approval Date: _____
Billing No.: _____ _____
Enrollment Date: _____ : _____ **JOAN M. MONICA** **IRVIN C. BO**
Start Date End Date EBAM Analyst Sr. Supervisor

Agency Accounting Remarks

Form with ATD within allowable limits? _____ Yes _____ No
Form start date (next payroll date following Approval): _____
DD-MMMM-YYYY _____
ALLAN D. ALBA – Manager

Accounting Remarks (Encoding of Premium)

Receiving Date of Form with Billing No.: _____
DD-MMMM-YYYY _____
RENY ANN CHARMAINE D. DIONISIO
Accounting Analyst

Agent

Receiving Date of COC with Form: _____ _____
DD-MMMM-YYYY **Agent**

Distribution (Email):
Copy 1: *Licensing 201 file;* ***Copy 2:*** *EBAM Master Policy Folder;* ***Copy 3:*** *Agent (Form attached to Confirmation to Cover);*
Copy 4: *Accounting Dept.*

Disclosure on Statement of Good Health

_____
Signature over Printed Name of the Agent