UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION
COCOLIFE Building, 6807 Ayala Avenue, Makati City 1226
Tel. No. 8810-7888 Fax No. 8812-9039 TIN 000-604-739-000 NV Website: www.cocolife.com

Policy No. _____

APPLICATION FOR PERSONAL ACCIDENT INSURANCE

POLICY OWNER

(Please PRINT answers / ANSWER completely.)

FIRST NAME	MIDDLE NAME	LAST NAME

AGE:	SEX:	CIVIL STATUS:	DATE OF BIRTH:	PLACE OF BIRTH:	NATIONALITY:

PERMANENT ADDRESS: No. and Street Village/Barangay

Municipality/City Province Zip Code

TEL. NO. (Landline):	MOBILE NO.:	EMAIL ADDRESS:
TIN NO.:	SSS/GSIS NO.:	OCCUPATION (Give exact duties and rank. If student, specify grade level.) / NATURE OF BUSINESS:

SOURCE OF FUNDS.: ☐ Salary/Professional Fees/Commission ☐ Savings ☐ Business ☐ Others (Please Specify): _____

CURRENT OFFICE ADDRESS (If Applicable):

BENEFICIAL OWNER: It refers to any natural person who ultimately owns or controls the customer and/or on whose behalf a transaction of activity is being conducted, or has ultimate control over a legal person or arrangement. In relation to a juridical entity, Beneficial Owner/s are individuals either owning or controlling at least 20% or more of the company's shares or voting rights.

Do you have a Beneficial Owner? ☐ Yes ☐ No (If Yes, please complete Beneficial Owner Form)

RELATIONSHIP TO PROPOSED INSURED

POLITICALLY EXPOSED PERSON ☐YES ☐NO

Politically Exposed Person refers to an individual who is or has been entrusted with prominent public position in (1) the Philippines with substantial authority over policy, operations or the use or allocation of government-owned resources; (2) a foreign State; or (3) an international organization.

PROPOSED INSURED (if other than Policy Owner)

(Please PRINT answers / ANSWER completely.)

FIRST NAME	MIDDLE NAME	LAST NAME

AGE:	SEX:	CIVIL STATUS:	DATE OF BIRTH:	PLACE OF BIRTH:	NATIONALITY:

PERMANENT ADDRESS: No. and Street Village/Barangay

Municipality/City Province Zip Code

TEL. NO. (Landline):	MOBILE NO.:	EMAIL ADDRESS:
TIN NO.:	SSS/GSIS NO.:	OCCUPATION (Give exact duties and rank. If student, specify grade level.) / NATURE OF BUSINESS:

SOURCE OF FUNDS.: ☐ Salary/Professional Fees/Commission ☐ Savings ☐ Business ☐ Others (Please Specify): _____

CURRENT OFFICE ADDRESS (If Applicable):

PLAN: ☐ Cocolife Protect ☐ Cocolife Protect Plus

FACE AMOUNT: ☐ PhP 500,000 ☐ PhP 1,000,000 ☐ Other: PhP _____

COVERAGE TERM: ☐ 1 ☐ 2 ☐ 3 Year(s)

ADDITIONAL RIDERS: ☐ **AMER** ☐ PhP 10,000 ☐ PhP 15,000 ☐ PhP 20,000 ☐ PhP 25,000

PREMIUM MODE: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Modal Premium: _____

PART I. BENEFICIARIES

Full Name	Address	Contact Number	Place of Birth	Date of Birth (mm/dd/yyyy)	Sex	Citizenship / Nationality	Relationship to Proposed Insured	% Share	Designation (Please Encircle) (P) Primary (C) Contingent		(R) Revocable (I) Irrevocable	
									P	C	R	I
									P	C	R	I
									P	C	R	I
									P	C	R	I
									P	C	R	I
									P	C	R	I

NOTE: *Beneficiaries share equally unless otherwise stated. If designation is not encircled/chosen, all beneficiaries will be deemed Primary & Revocable.*

PART II. HEALTH DECLARATION

To be answered by the Policy Owner/Payor and the Proposed Insured if age 15 or over	Policy Owner		Proposed Insured	
	YES	NO	YES	NO
1. Do you possess sound health and able to perform the normal activities in pursuit of your livelihood free from any physical or mental infirmity?	☐	☐	☐	☐
2. Have you ever engaged in hazardous sports or avocations such as car racing, diving, mountain climbing, etc.?	☐	☐	☐	☐
3. During the past five years: Have you sustained any injuries from accidents? Have you suffered from any disease and illness?	☐ ☐	☐ ☐	☐ ☐	☐ ☐
4. Do you have any physical defect or deformity, impairment of hearing or vision?	☐	☐	☐	☐
5. Have you ever been told you have cancer, diabetes, epilepsy, heart trouble, high blood pressure or tuberculosis?	☐	☐	☐	☐
6. Have you ever had any life, accident, disability, or hospitalization insurance denied, deferred, cancelled, refused renewal, modified, or rated?	☐	☐	☐	☐

If you answered "NO" to question number 1 or "YES" to any of the questions from number 2 to 6, kindly give full details. Details may consider attending physician, nature of consultation, date, etc. Use a separate sheet and sign it.

To be answered if Proposed Insured is less than 15 years old	YES	NO
1. Is the child now in good health?	☐	☐
2. Is the child now normal in every way?	☐	☐
3. Is the child now receiving treatment by diet, medicine, or any other means?	☐	☐
4. During the past five years or during the life of the child if less than 5 years old: Has the child sustained any injuries from accidents? Has the child suffered from any disease and illness?	☐ ☐	☐ ☐
5. Does the child have any physical defect or deformity, impairment of hearing or vision?	☐	☐
6. Has the child ever been diagnosed to have cancer, diabetes, epilepsy, heart trouble, high blood pressure or tuberculosis?	☐	☐

If you answered "NO" to any of the questions from number 1 to 2 or "YES" to any of the questions from number 3 to 6, kindly give full details. Details may consider attending physician, nature of consultation, date, etc. Use a separate sheet and sign it.

FOREIGN ACCOUNT TAX COMPLIANCE ACT ("FATCA")

	Policy Owner	Proposed Insured
You acknowledge that you are a United States ("U.S.") Person[1] under U.S. Laws	☐	☐
You acknowledge that you are NOT a U.S. Person under U.S. Laws	☐	☐
But you have at least one of the following U.S. Indicia[2]	☐	☐
And you have no U.S. Indicia	☐	☐

***** You agree to advise us as soon as possible of any change in the information that you provided to us.*****

[1] U.S. Person means: a) U.S. citizen (including dual citizens); b) U.S. permanent resident (green card holders); c) Individual that have stayed for a substantial number of days in the U.S. (ie. More than 31 days during the current year or a total of 183 days during the 3-year period that includes the current year and the 2 years immediately before that) d) U.S. corporations, partnerships, and trusts created under U.S. law; or e) Foreign (non-U.S. registered) entities that are substantially owned by a U.S. Person (more than 10% of the entity by vote or value)

[2] a) U.S. Place of Birth; b) U.S. mailing or residence address (including a U.S. post office box) c) U.S. telephone number; d) A standing instruction to transfer funds to an account maintained in the United States; e) A currently effective power of attorney or signatory authority granted to a person with a U.S. address; or f) An "in-care-of" or "hold mail" address that is your sole address.

DATA PRIVACY POLICY

Cocolife upholds an individual's data privacy rights and assures that all your personal information, sensitive personal information and privileged information (collectively, "Personal Data"), collected and to be collected, are processed in compliance to the Data Privacy Act of 2012 (R.A. No. 10173) and its Implementing Rules and Regulations (IRR).

To enable us to perform our process related with your application for life insurance and other various products, it is important that COCOLIFE collects, uses and stores your personal data. Thus, we are using your information to:

- Administer your policy, with any person or organization who has information about you, including your employer if applicable, authorized institutions, investigative agencies, insurers and reinsurers;
- Prevent Money Laundering or Terrorism-Financing activities; and
- Perform any other action as may be necessary to implement the terms and conditions of our contract.

When you provide information other than yours, you certify that you obtained their consent to disclose and process those information of your parents, spouse, children, dependent, or about another person like stockholders, directors, officers and employees.

We may share your personal data only to the extent that is reasonable and necessary to: our employees and officers handling your orders and request; our subsidiaries, affiliates, partners, joint venture & other third-party service providers performing financial, administrative, technical and other ancillary services, and; person or entity that we contractually entered with, that ensures the confidentiality standard we implement and adheres to the DPA.

Cocolife shall ensure that personal data under its custody are protected against any accidental or unlawful destruction, alteration and unlawful disclosure. It implements appropriate security measures in storing collected personal data. Personal data will be safely destroyed through secure means, after the lapse of the retention period provided by law or as determined by Cocolife.

Kindly browse through our Privacy Policy Statement in our company website to know more about the importance of your rights under the DPA. You may also send your concerns to: COCOLIFE Data Protection Officer at COCOLIFE Building, 6807 Ayala Avenue, Makati City or e-mail address at dpo@cocolife.com.

By signing below, you acknowledge and agree with the foregoing and certify that you explicitly consent to the collection, processing, sharing, storing of your personal and sensitive personal information by COCOLIFE

☐ **This consent shall apply to all of my existing policies with COCOLIFE.**

CONSENT

During the effectivity of the contract/policy, I/we agree to the following: (1) In case the Company 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, the Company may: (a) impose measures to restrict the services available or prohibit any further transactions on the contract policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, the Company may terminate business relationship. The exercise of the company of this measure shall only entitle the client/ customer to receive the unused portions of premium or withdrawal value, if any, whichever is applicable; and (2) Be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation of financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

I/We, the undersigned hereby certify that I/We explicitly and unambiguously consent to the collection, processing, sharing, storing of my/our personal and sensitive personal information by COCOLIFE for purposes described in the Data Privacy Policy and FATCA. I/We hereby certify that I/We carefully understood and comprehend the terms above before giving my/our consent.

The electronic version of your Insurance Policy will be sent to your indicated email address once this application is approved. For printed copy of your insurance policy, charges may apply.

☐ Request for a printed copy of my Insurance Policy

I hereby agree that the above questions and answers shall be considered in lieu of a medical examination as part of my application for insurance. I hereby declare that all the foregoing answers and statements are complete, true and correct to the best of my knowledge and belief. I hereby agree that if there is any misinterpretation in the above statements material to risk, COCOLIFE shall have the right to reject and declare such insurance null and void.

_____
Signature of Policy Owner

(For multiple policy signatories, please sign below)

_____

_____

_____
Signature of Proposed Insured
(if age 18 & over)

_____
Printed Name & Signature of Parent

_____
Date and Place Signed

I/We hereby certify that I/we have asked & carefully explained each question before truly and accurately recording each answer as supplied by Policy Owner and/or Proposed Insured prior to the application being signed.

_____
Name and Signature of Agent

_____
Code No. of Agent

_____
Name and Signature of Agent

_____
Code No. of Agent

DECLARATION ON THE PROPOSED REPLACEMENT OF EXISTING POLICY(IES)

(PART I - FOR THE POLICY OWNER TO ANSWER)

1) Total life insurance in-force now carried by Policy Owner or Proposed Insured:

Policy Owner or Insured	Company	Policy Number	Date Issued	Amount of Basic Coverage	Accident Rider

2) Has there been or will there be any change in any existing insurance in force (or for any intention of discontinuing or replacing the insurance coverages now in force) in favor of this application? ☐ Yes ☐ No

If yes, please furnish details (name of company, policy number & amount of insurance being replaced.)

3) Is there any intention of paying the premiums for the insurance applied for by a policy loan from any existing policy? ☐ Yes ☐ No

If yes, please state company, policy number and amount of insurance.

Signature of Policy Owner

REMINDER

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

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

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.

(PART II - FOR THE AGENT TO ANSWER)

1) Has there been or will there be any change in any existing insurance in force on the life of Policy Owner or Proposed Insured in favor of this application?
☐ Yes ☐ No

2) Will premiums for the insurance applied for be paid by policy loan from any existing policy? ☐ Yes ☐ No

If yes, have the policy owner complete a Replacement Notification Form.

Signature of Agent

This form shall be made part of the Application for Insurance.

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REPLACEMENT NOTIFICATION FORM
(To be accomplished by Policy Owner)

Name of Proposed Insured _____ Date of Birth _____

Address _____

_____

Name of Policy Owner (if other than insured) _____

REPLACING YOUR LIFE INSURANCE POLICY?

If you are thinking about buying a new policy and discontinuing, borrowing against or changing an existing one, your decision could be a good one or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy. Here are some points to keep in mind.

- Compare premiums for your existing and proposed policies. Look at the premiums which you will pay not only in the first year but in later years also. The premiums may be lower because the type of plan is different. Does the proposed plan meet your needs? The premiums may also be higher because your health condition or age has changed or because of the type of plan.
- Compare cash values if either policy has cash values. How do the cash values compare at the end of 5th, 10th and 20th policy years and at attained age 65?
- The Incontestable and Suicide provisions will start again.
- If you are borrowing against an existing policy, both the death benefit and cash value of that policy are reduced by the amount of the loan. Also, annual interest is charged on a policy loan.

EXISTING POLICIES TO BE REPLACED

Company Name (as it appears on the policy) _____

Name of Insured (as it appears on the policy) _____

Policy Number of Insured _____

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

_____ _____
Date Signature of Policy Owner

Note: The replacing insurer should furnish a copy of this form to the issuer of the policy being replaced within seven (7) days from receipt of application and before actually issuing the new policy.

This form shall be made part of the Application for Insurance.

AGENT'S REPORT

ON CHILD (below 15)

1. Did you personally see the child proposed for insurance? ☐ Yes ☐ No
2. Does the child appear in good health? ☐ Yes ☐ No
3. How long have you known the child?
4. Present residence of child
5. Are you personally acquainted with the family? ☐ Yes ☐ No
6. How many brothers and sisters has the child?
7. Are they all insured? If no, why not? ☐ Yes ☐ No
8. Are you related to the child? ☐ Yes ☐ No

If so, give relationship

ON PROPOSED INSURED OR POLICY OWNER

1. How long have you known Proposed Insured or Policy Owner (if Proposed Insured is over age 15)

How well?

2. Does Proposed Insured appear healthy ☐ Yes ☐ No
3. Are you related to the Proposed Insured? ☐ Yes ☐ No

If so, give relationship

ON POLICY OWNER'S SPOUSE

Full Name			
Date of Birth		Age	
Occupation			

Name of Company

Annual Income

Amount of Life Insurance Carried

To be completed if corporation or business associate is beneficiary or owner of the policy

(a) Value of business. 1) Net Worth P _____ (submit latest audited F/S)

2) Fair Market Value P _____

(b) Proposed Insured's interest in Company

Percent Owned _____%

(c) Names of other key officers or co-owners and amount of business insurance on their lives. (If any not insured, explain)

NAME	POSITION IN COMPANY	% OWNED	INTEREST IN CO / BUSINESS INSURANCE NOW CARRIED	AMOUNT APPLIED FOR

SHORT NARRATIVE ON PROPOSED INSURED

Please discuss in details the Proposed Insured's working environment, lifestyle, morals, habits, hobbies, health and financial standing

REMARKS / ADDITIONAL INFORMATION

Policy Owner's ID Presented

Type: _____ Issue Date: _____ No: _____ Expiration Date: _____

Proposed Insured's ID Presented

Type: _____ Issue Date: _____ No: _____ Expiration Date: _____

I / We hereby certify that I / we personally solicited this application, and that the answers in this Agent's Report are complete and true to the best of my / our knowledge and belief.

_____
Signature of Agent

_____
Date

FOR BRANCH OFFICE USE ONLY:

O.R. No. _____ Payment Received _____ Date Received _____

_____
Signature of Cashier