COCOLIFE

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

Policy Number: _____

PART I - APPLICATION FOR VARIABLE LIFE INSURANCE

POLICY OWNER

Surname	First Name	Middle Name	Suffix	Nickname

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

Civil Status	Sex	Citizenship/Nationality

TIN Number	Telephone Number

SSS/GSIS Number	Mobile Number

E-mail Address	Fax Number

Present Address _____ Zip Code _____

Permanent Address ☐ Same as Present Address

Source of Funds
☐ Salary/Professional Fees/Commission
☐ Savings ☐ Business
☐ Others (Please specify) _____

Current Office Address

Name of Employer
Nature of Business
Office Number

Occupation (Give exact duties and rank. If student, specify grade level)

Annual Income
Months / Years of Service

PROPOSED INSURED (if other than Policy Owner)

Surname	First Name	Middle Name	Suffix	Nickname

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

Civil Status	Sex	Citizenship/Nationality

TIN Number	Telephone Number

SSS/GSIS Number	Mobile Number

E-mail Address	Fax Number

Present Address _____ Zip Code _____

Permanent Address ☐ Same as Present Address

Source of Funds
☐ Salary/Professional Fees/Commission
☐ Savings ☐ Business
☐ Others (Please specify) _____

Current Office Address

Name of Employer
Nature of Business
Office Number

Occupation (Give exact duties and rank. If student, specify grade level)

Annual Income
Months / Years of Service

BENEFICIAL OWNER
It refers to any natural person who ultimately owns or controls the customer and/or on whose behalf a transaction or 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 accomplish, the Certification of Beneficial Owner form.

RELATIONSHIP TO POLICY OWNER

For Worksite Use Only: Owner Detail
Company Code / Class / Employee Number

For DepEd Use Only: Owner Detail
Employee Number / Branch / Plant / Region / Division / Station

Variable Life Plan Name	Face Amount (FA)	Premium	Years to Pay	Mode of Payment
				☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

Death Benefit Option
☐ Option 1: Level Death Benefit (Higher of FA or Fund)
☐ Option 2: Increasing Death Benefit (FA + Fund)
☐ Others: _____

Plan Currency
☐ Peso
☐ Dollar
☐ Others: _____

Additional Benefits Desired
☐ AD&D
☐ WPD
☐ PBR - DD
☐ PBR - DO
☐ CIBR Amount of Coverage _____
☐ Rider _____
Amount of Coverage _____
☐ Rider _____
Amount of Coverage _____

Fund Allocation Instruction (Peso)

Peso Fixed Income Fund	=	_____ %
Peso Bond Fund	=	_____ %
Peso Equity Fund	=	_____ %
Cocolife Asian Multi-Asset Income Fund	=	_____ %
Cocolife Global Consumer Trends Fund	=	_____ %
Others: _____	=	_____ %
_____	=	_____ %
TOTAL	=	100 %

Fund Allocation Instruction (Dollar)

Dollar Bond Fund	=	_____ %
Others: _____	=	_____ %
_____	=	_____ %
_____	=	_____ %
TOTAL	=	100 %

BENEFICIARIES

Full Name	Address	Contact Number	Place of Birth	Date of Birth (mm/dd/yyyy)	Sex	Citizenship/ Nationality	Relationship to the 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.*

(Please check applicable answer)	Policy Owner		Proposed Insured		Give full details for all "YES" answers. (use extra paper if necessary)
Has the Policy Owner or Proposed Insured:	Yes	No	Yes	No	
a) made any application(s) for life and health insurance now pending or contemplated?					
b) made an application for life insurance or for reinstatement thereof which was declined, postponed, cancelled or modified in kind, amount or rate? If so, state companies and dates.					
c) made or intend to make aerial flight other than as passenger? If so, submit aviation questionnaire.					
d) ever engaged in or intend to engage in skin/scuba diving, car racing, mountain/rock climbing, bungee jumping, parachuting or other hazardous sports or avocation? If so, submit questionnaire.					
e) any intention of traveling, living or working outside the Philippines in the next 2 years? If "yes" in which country, when and for how long?					
f) been active in politics as a candidate, an elected official or in any other capacity during the last 5 years? If yes, give details.					
g) received any threat on his/her life?					
h) applied for or received any claim payment or pension for any sickness, accident or injury?					
i) been arrested, charged, convicted of a felony or crime or been involved in litigation or a court case?					

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.**

AGREEMENT

1. All the foregoing answers/statements and those that I/we make to the Company's medical examiner (if applicable) in continuation of this Application and any amendments thereto, are complete, true and correctly recorded and shall form part and be the basis of the insurance contract herein applied for;
2. There shall be no contract until the first premium is paid and the Policy is delivered to me/us while in good health. If the policy does not take effect, any amount deposited will be refunded to me/us, if living, otherwise to the beneficiary named herein;
3. I/We warrant the eligibility of the beneficiary named herein, and will not in the future designate any legally ineligible beneficiary. Should the Company, believing in good faith, pay the policy proceeds to an ineligible beneficiary, said payment shall free the Company from Liability, if within 60 days from the presentation by the ineligible beneficiary of the claim and proof of death, no adverse claim is filed with the Company by the person entitled to said proceeds;
4. I understand and agree to the following:
   - Premiums to be invested will be the remaining premium after the deduction of premium charges;
   - If after payment of premiums it was found out that I am not insurable due to medical reasons, the amount refundable to me/us shall be the total Premium Charges, Monthly Administrative Charges, Insurance Charges and Other Charges paid and Total Account Value;
   - For the Unitized Variable Funds such as Peso Fixed Income Fund, Peso Bond Fund, Peso Equity Fund, Cocolife Asian Multi-Asset Income Fund, Cocolife Global Consumer Trends Fund and Dollar Bond Fund, the company will use the unit price on the valuation date as stated in the policy contract. Insurance charges and other applicable charges will be deducted by cancellation of units equivalent to the amount of the charges; and units may rise or fall in accordance with the separate fund's experience.
   - If upon receipt of the policy contract and I decided to return the policy within 15 days from the date of receipt, the amount refundable to me/us will be the total Premium Charges, Monthly Administrative Charges, Insurance Charges and Other Charges paid and the Total Account Value;
5. Article 1250 of the Civil Code of the Philippines (R.A. 386) shall not apply to any payments made or to be made by either party to any contract of insurance or policy issued pursuant to this application and that my/our acceptance of any policy issued shall be ratification of any modification made by Home Office.
6. No agent or medical examiner is authorized to accept risks, pass upon insurability, make/modify contracts or waive any of the Company's rights/requirements.
7. I/We fully understood and agreed to all conditions stated herein.

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 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

Dated at _____ on _____ .

Left Thumbmark	Right Thumbmark

Thumb mark of Policy Owner
(if unable to sign or if signature is in block letters)

Left Thumbmark	Right Thumbmark

Thumb mark of Proposed Insured or Parent of Minor Insured
(if unable to sign or if signature is in block letters)

_____
Signature of Policy Owner/s

(For multiple policy signatories, please sign below)

_____

_____

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

With the consent of parent
(If Proposed Insured is below 18 years)

_____
Printed Name & Signature of Parent

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

Signature of Agent	Name of Agent (in Print)	Code No. of Agent
Signature of Agent	Name of Agent (in Print)	Code No. of Agent

FOR HEAD OFFICE USE ONLY
Referred by:
Branch / Business Unit
Employee No.
Date

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.

PART II. NON-MEDICAL DECLARATION (May be omitted if to be medically examined)

Name of Policy Owner _____ Name of Proposed Insured _____

Height: _____ ft _____ in/_____cm Weight: _____ lbs/ _____ kg Height: _____ ft _____ in/_____cm Weight: _____ lbs/ _____ kg

To be answered by the Policy Owner and the Proposed Insured if age 15 or over. Please encircle applicable items.	(Please Check) Policy Owner		Proposed Insured		Details of "Yes" answers. Identify question number and include name & address of attending physician, date examined, duration, diagnosis & medical treatment.
A. Has the Policy Owner or Proposed Insured:	Yes	No	Yes	No	
1.) been advised of, treated for, or had any known indication of: heart disease, high blood pressure, stroke, chest pain, asthma, TB or any chronic lung disease, ulcer or other digestive disorder, kidney problem, hepatitis or other liver disease, goiter, diabetes, polio, problems with spleen, anemia, bleeding or other blood disorder, paralysis, fainting, convulsion, epilepsy or other neurologic disorder, cerebral palsy, tumor, cyst, cancer, mental or psychological problems, sexually transmitted disease, weakened immune system such as but not limited to HIV infection or AIDS, alcoholism or drug abuse?					
2.) had any other physical, mental or psychological illness / injury or impairment not mentioned above?					
3.) consulted any physician, received medical advice, care, medication or medicines such as steroid tablets, chemotherapy, radiotherapy, treatment, intake of cosmetic / hormonal pills, history of cosmetic procedure/s or medical implants, been confined in a hospital, clinic or similar institution in the last 5 years?					
4.) had any abnormal urine or blood test, chest x-ray, ECG, ultrasound or other diagnostic or physical exams?					
B. Does the policy owner or proposed insured use alcohol or tobacco? If yes, please indicate amount and frequency of consumption.					

TO BE ANSWERED IF PROPOSED INSURED IS UNDER AGE 15

1.) Is the child now in good health?			
2.) Is the child normal in every way?			
3.) Is the child now receiving treatment by diet, medicine or any other means?			
4.) Has child have any birth injury or do you know of any congenital or hereditary abnormality, disease or trait which may effect child's future health?			
5.) Regarding child, name below all causes for which a doctor has been consulted in the last 5 years. If none, indicate "NONE"			

DISEASE, INJURY OR OPERATION	DATE	RESULT	NAME & ADDRESS OF DOCTORS

FAMILY HISTORY

Have your parents or siblings developed any of these diseases before age 60? ☐ **Yes** ☐ **No** **If yes, indicate below the age when disease developed:**

FOR POLICY OWNER

	Coronary	Diabetes	Cancer	Mental Illness	Current Age or Age at Death
Father					
Mother					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Sibling 5					

FOR PROPOSED INSURED

	Coronary	Diabetes	Cancer	Mental Illness	Current Age or Age at Death
Father					
Mother					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					
Sibling 5					

FOR FEMALES ONLY

Is the Policy Owner now pregnant? ☐ Yes ☐ No If yes, how many weeks/months? _____
Expected date of delivery _____
Have you had any miscarriage or complication of pregnancy or delivery? ☐ Yes ☐ No
Date of last delivery? _____

FOR FEMALES ONLY

Is the Proposed Insured now pregnant? ☐ Yes ☐ No If yes, how many weeks/months? _____
Expected date of delivery _____
Have you had any miscarriage or complication of pregnancy or delivery? ☐ Yes ☐ No
Date of last delivery? _____

Dated at _____ on _____

Left Thumbmark | Right Thumbmark

_____
Signature of Policy Owner
(For multiple signatories, please sign below)

_____
Signature of Proposed Insured (if Age 18 & Over)

With the consent of parent (If Proposed Insured is below 18 years old)

_____
Printed Name and Signature of Parent

Thumb mark of Policyowner
(if unable to sign or if signature is in block letters)

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

Left Thumbmark | Right Thumbmark

Signature of Agent	Name of Agent (in Print)	Code No. of Agent
Signature of Agent	Name of Agent (in Print)	Code No. of Agent

Thumb mark of Insured/Parent of Minor Insured
(if unable to sign or if signature is in block letters)

IMPORTANT NOTICE

The underwriting process (evaluation and classification of risk) is necessary to assure reasonable cost of insurance and provide a mechanism by which policy owners pay their fair share of the cost. In considering your application, information from various sources is considered, including your own statements , the result of your physical examination (if required), and any reports we obtain from doctors of medical facilities where you have been attended. An investigative report may also be obtained which will provide applicable information concerning character, general reputation, personal characteristics and mode of living. This information will be obtained through personal interviews with your friends, neighbors and associates.

"DISCLOSURE: 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."

AUTHORIZATION

By this form (or a photographic copy of it), I authorized any licensed doctor, medical practitioner, clinic, hospital, or other medical or medically-related facility, insurance company, the Medical Information Database, or other person, organization, or institution, that has any records or knowledge on me or the proposed insured for whom insurance application is made or my health or the proposed insured's health, to give to UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION also known as Cocolife, or its reinsurers, any such information, all to the extent permitted by law.

Date	Signature of Policy Owner	Signature of Proposed Insured / Parent's Consent for Minor Insured

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