

Policy Number: \_\_\_\_\_

## PART I - APPLICATION FOR INSURANCE

POLICY OWNER					PROPOSED INSURED (if other than Policy Owner)				
Surname	First Name	Middle Name	Suffix	Nickname	Surname	First Name	Middle Name	Suffix	Nickname
Date of Birth (mm/dd/yyyy)		Age		Place of Birth	Date of Birth (mm/dd/yyyy)		Age		Place of Birth
Civil Status		Sex		Citizenship/Nationality	Civil Status		Sex		Citizenship/Nationality
TIN Number		Telephone Number			TIN Number		Telephone Number		
SSS/GSIS Number		Mobile Number			SSS/GSIS Number		Mobile Number		
E-mail Address		Fax Number			E-mail Address		Fax Number		
Present Address				Zip Code	Present Address				Zip Code
Permanent Address		<input type="checkbox"/> Same as Present Address		Source of Funds <input type="checkbox"/> Salary/Professional Fees/Commission <input type="checkbox"/> Savings <input type="checkbox"/> Business <input type="checkbox"/> Others (Please specify) _____	Permanent Address		<input type="checkbox"/> Same as Present Address		Source of Funds <input type="checkbox"/> Salary/Professional Fees/Commission <input type="checkbox"/> Savings <input type="checkbox"/> Business <input type="checkbox"/> Others (Please specify) _____
Current Office Address		Name of Employer			Current Office Address		Name of Employer		
		Nature of Business					Nature of Business		
		Office Number					Office Number		
Occupation (Give exact duties and rank. If student, specify grade level)		Annual Income			Occupation (Give exact duties and rank. If student, specify grade level)		Annual Income		
		Months / Years of Service					Months / Years of Service		
<b>BENEFICIAL OWNER</b> 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.					<b>RELATIONSHIP TO POLICY OWNER</b>				
Do you have a Beneficial Owner? <input type="checkbox"/> YES <input type="checkbox"/> NO "If YES", please accomplish, the Certification of Beneficial Owner form.									
<b>For Worksite Use Only: Owner Detail</b> Company Code / Class / Employee Number					<b>For DepEd Use Only: Owner Detail</b> Employee Number / Branch / Plant / Region / Division / Station				

Plan Name		Face Amount (FA)		Premium		Years To Pay		Mode of Payment <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly						
<b>Additional Benefits Desired</b> <input type="checkbox"/> WPD <input type="checkbox"/> TILB <input type="checkbox"/> ABR <input type="checkbox"/> HBR/UNITS <input type="checkbox"/> DDBR <input type="checkbox"/> HBR+/UNITS <input type="checkbox"/> ADD <input type="checkbox"/> CIBR/FACE AMOUNT <input type="checkbox"/> ADB <input type="checkbox"/> <input type="checkbox"/> PBR DO <input type="checkbox"/> <input type="checkbox"/> PBR D&D <input type="checkbox"/>				<b>Premium Default Option (if applicable)</b> <input type="checkbox"/> Reduced Paid-Up (RPU) <input type="checkbox"/> Extended Term Insurance (ETI)* <input type="checkbox"/> Premium Loan  <i>*If no option is chosen, the ETI option will be the premium default option that will automatically apply for standard lives. If ETI is not available, the RPU option shall automatically apply.</i>				<b>Dividend Option (For Participating Plan only)</b> <input type="checkbox"/> Cash <input type="checkbox"/> Accumulate with Interest** <input type="checkbox"/> Premium Payment <input type="checkbox"/> Paid-Up Additions  <b>**This option will automatically apply if no option is elected. Please note that before any option applies, the policy owner authorizes Cocolife to use his/her dividends to pay current loan interest and current loan principal.</b>						
<b>BENEFICIARIES</b>		Address		Contact Number	Place of Birth	Date of Birth (mm/dd/yyyy)	Sex	Citizenship / Nationality	Relationship to Proposed Insured	% Share	Designation (Please Encircle)			
Full Name											(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)
	Yes	No	Yes	No	
Has the Policy Owner or Proposed Insured:					
a) made any application(s) for life or 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 <sup>1</sup> under U.S. Laws	<input type="checkbox"/>	<input type="checkbox"/>
You acknowledge that you are NOT a U.S. Person under U.S. Laws	<input type="checkbox"/>	<input type="checkbox"/>
But you have at least one of the following U.S. Indicia <sup>2</sup>	<input type="checkbox"/>	<input type="checkbox"/>
And you have no U.S. Indicia	<input type="checkbox"/>	<input type="checkbox"/>

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

<sup>1</sup> 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)

<sup>2</sup> 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

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| <ol style="list-style-type: none"> <li>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;</li> <li>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.</li> <li>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</li> </ol> | <ol style="list-style-type: none"> <li>with the Company by the person entitled to said proceeds.</li> <li>4. 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.</li> <li>5. The Proposed Insured consents to the insurance herein applied for and agrees that any policy issued hereunder shall belong to and be subject to the exclusive control and disposition of the Policy Owner.</li> <li>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.</li> <li>7. I/We fully understood and agreed to all conditions stated herein.</li> </ol> |
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## 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 \_\_\_\_\_.

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

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 Insured/Parent of Minor Insured  
(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 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
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>

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.)*

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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.*

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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 ☐ No2) 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.*

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Signature of Agent

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

**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)				Details of "Yes" answers. Identify question number and include name & address of attending physician, date examined, duration, diagnosis & medical treatment.
	Policy Owner		Proposed Insured		
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"			
<b>DISEASE, INJURY OR OPERATION</b>	<b>DATE</b>	<b>RESULT</b>	<b>NAME &amp; ADDRESS OF DOCTORS</b>

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

FOR FEMALES ONLY		FOR FEMALES ONLY	
Is the Policy Owner now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks/months? _____	Is the Proposed Insured now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks/months? _____	Expected date of delivery _____	Expected date of delivery _____
Have you had any miscarriage or complication of pregnancy or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had any miscarriage or complication of pregnancy or delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last delivery? _____	Date of last delivery? _____

Dated at \_\_\_\_\_ on \_\_\_\_\_

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

Signature of Proposed Insured (if Age 18 &amp; Over)

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

Printed Name and Signature of Parent \_\_\_\_\_

I/We hereby certify that I/we have asked &amp; 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.

Signature of Agent \_\_\_\_\_

Name of Agent (in Print) \_\_\_\_\_

Code No. of Agent \_\_\_\_\_

Signature of Agent \_\_\_\_\_

Name of Agent (in Print) \_\_\_\_\_

Code No. of Agent \_\_\_\_\_

Left Thumbmark

Right Thumbmark

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

Left Thumbmark

Right Thumbmark

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](http://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) (b) Proposed Insured's interest in Company  
2) Fair Market Value P \_\_\_\_\_ 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