Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 8888 6268
Website: www.manulife.com.ph
Email: phcustomercare@manulife.com

Policy Details Change Form

Health Insurance

Please answer completely and accurately and use black ink. Please countersign on any corrections or erasures. The "Company" means The Manufacturers Life Insurance Co. (Phils), Inc.

General Information

Policy Number	Email Address	Mobile Number +63
Owner Last Name	Owner First Name	Owner Middle Name ☐ Do not know / not applicable
Insured Last Name	Insured First Name	Insured Middle Name ☐ Do not know / not applicable

Change Plan (decrease / increase)

Requests must be submitted no earlier than sixty (60) days and no later than thirty (30) days before the renewal date.

	From	To
Plan		
Annual Benefit Limit		
Annual Deductible		

If you are applying to increase your annual benefit limit or decrease your annual deductible, please indicate your reason:

☐ Increase in income
☐ Termination of existing HMO or medical insurance coverage
☐ Others (please specify): _____

IMPORTANT NOTE: For increase in Annual Benefit Limit or decrease in Annual Deductible, kindly fill out the **Health Statement** and **Change of Client Information** below.

Health Statement

In this section, only the information of the Insured should be declared.	Insured	
Current Height: _____ ☐ ft./in. ☐ cm. **Current Weight:** _____ ☐ lbs. ☐ kg.	**Yes**	**No**
1. Have you ever been declined, postponed, charged higher than standard premium rates, or offered modified or restricted benefits for life, critical illness, disability or health insurance?	☐	☐
2. Have you ever had, been told that you have, had symptoms of, or been treated for cancer or lumps/growth of any kind, diabetes mellitus, raised blood pressure, chest pain, heart attack, stroke, cerebrovascular disease, any disease or disorder of the heart or blood vessels (e.g. coronary artery), the lungs, blood, kidney(s), liver, bowel or stomach, pancreas, hepatitis B or C (including Hepatitis B carrier), mental illness, rheumatoid arthritis, HIV or AIDS, alcoholism and/or drug addiction, neurological disorder (e.g. Multiple Sclerosis, Parkinson's disease, Motor Neuron Disease), physical impairments (e.g. loss of sight or hearing), or any other major illness?	☐	☐
3. Have any of your natural parents or siblings had Dementia (including Alzheimer's disease), Cancer, Cardiomyopathy, Diabetes, Heart Disease, Stroke, Huntington's' Disease, Parkinson's Disease, Polycystic Kidney Disease, Familial Adenomatous Polyposis, Motor Neuron Disease, Multiple Sclerosis or Muscular Dystrophy? If yes, please indicate family member, condition/illness, age at onset and age at death (if applicable).	☐	☐

Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 8888 6268
Website: www.manulife.com.ph
Email: phcustomercare@manulife.com

Policy Details Change Form

Health Insurance

Health Statement (continuation)

4. During the past 5 years, have you sought, are currently seeking, or do you plan to seek any treatment at any hospital, clinic, or doctor for any illness, injury, medical advice, operation or treatment and/or for any diagnostic test (such as an ECG, X-ray, blood test, etc.) not mentioned above, (excluding minor ailments like common colds, flu, minor accidental injuries which you have recovered from, routine health check-up with normal results) and/or are you taking medication on a regular ongoing basis?	☐	☐
5. Do you currently have any signs or symptoms of illness or disease for which you have not sought medical advice?	☐	☐

6. How would you describe your smoking habit? ☐ Never smoke ☐ Smoke up to 30 cigarettes per day ☐ Smoke more than 30 cigarettes per day

Remarks: If you responded yes to any of the questions on Health Statement, please provide details. Write the question number and provide the conditions, dates, durations, results, full name and address of doctors, hospitals and clinics.

Change of Client Information (Insured)

	From	To
Occupation		
Medical Condition		
Avocation		
Country of Residence		
Place of Work		

Note: Your premium may be adjusted due to the changes above which will be subject to the review and acceptance of the Company.

Change of Financial Advisor

Insurance Advisor	From: Name of current Financial Advisor
	To: Name of preferred Financial Advisor
	Reason:

Change of Payment Details

Payment Mode

☐ Annual
☐ Semi-Annual
☐ Quarterly
☐ Monthly

*For Monthly and Quarterly Mode – Enrollment to Auto-Charge Arrangement (Debit/Credit Card) or Auto-Debit Arrangement is required.

Regular Payment Scheme

☐ Credit Card ☐ Auto-Debit Arrangement

*Manulife Account must be enrolled in the accredited bank, additional forms and requirements must be submitted.

Manulife

The Manufacturers Life Insurance Co. (Phils.), Inc.
Head Office: 10th Floor NEX Tower, 6786 Ayala Avenue, Makati City, 1229, Philippines
Customer Care: +632 8884 7000
Domestic Toll-Free: 1 800 1 8888 6268
Website: www.manulife.com.ph
Email: phcustomercare@manulife.com

Policy Details Change Form

Health Insurance

Declaration and Agreement

By signing this form and continuing to avail of the Company's products and services, I/we declare and agree that:

1. I/We agree to receive or access the policy contract, billing notice/s or any other corporate correspondence, documents or information pertaining to such policy electronically/digitally by making use of a computer, mobile or any digital device.
2. I/We agree that the cost and expense to obtain or configure suitable software, devices and/or equipment to receive or access such documents shall be borne by me/us.
3. I/We agree and understand that transmission of information or communication over the internet may be subject to interruption, transmission blackout and delayed transmission due to the internet traffic, or incorrect data may be transmitted due to the public and open nature of the internet or otherwise. The Company, shall not be responsible for any loss of accuracy or timeliness of any information or communication arising from the said reasons or in relation to any malfunctions in communication facilities that are out of control of the Company.
4. I/we agree that the information I/we provided can be processed by the Company, including its employees, affiliates, subsidiaries, business partners, any member of the Manulife Financial Group, advisors, representatives, local and foreign authorities having jurisdiction over companies within the Manulife Financial Group, external auditors/counsels and its third party service providers in accordance with the Data Privacy Act of 2012, as may be amended from time to time, relevant regulations and the Company's privacy policy and notice available at https://www.manulife.com.ph/Customer-Privacy-Policy.
5. During the effectivity of the policy contract, I agree to the following: 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 my fault, the Company may apply the following: (a) 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, terminate business relationship, which shall only entitle me to receive the unused portions of premium or withdrawal value, if any, whichever is applicable. I also agree to 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.
6. In accordance with the Insurance Commission's Circular Letter No. 2016-54, as may be amended from time to time, my (Insured) 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 my information in order to protect my 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.
7. I/we have read the above questions, statements and answers and certify that the information provided above is true, correct and complete based on my/our personal knowledge and official records. If signing for the legal entity identified above, I/we certify that I/we have the capacity to sign for such legal entity. I/we also allow the Company to update my/our records based on the information found in this form and to use such to administer and service the policy. I agree to receive a confirmation email and/or letter to inform me once the changes are effected.
8. I understand that if I designated an irrevocable beneficiary, I cannot make any changes under the policy that will adversely affect the ownership interests of the irrevocable beneficiary. These changes include, but are not limited to, surrendering the policy, change plan, remove family member, or even changing an irrevocable beneficiary, without the written consent of the irrevocable beneficiary/ies.

_____
Owner Signature over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

_____
Irrevocable Beneficiary/ies (if any) Signature over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

_____
Insured Signature over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

_____
Financial Advisor Signature over Printed Name

Date: _____ Place: _____
(mm/dd/yyyy)

FA Code: _____

For Manulife use Only

Valid IDs: Type: _____ ID#_____ ☐ Documents Presented: _____

Documents received and validated by: _____ _____ _____
Name of CSO Branch Date (mm/dd/yyyy)