COCOLIFE
UNITED COCONUT PLANTERS LIFE ASSURANCE CORPORATION
COCOLIFE Building 6807 Ayala Avenue Makati City 1226
Tel. No. 8812-9015 Fax No. 8812-9039 / 8812-9040 • Website: www.cocolife.com

Application No. _____

Policy No. _____

APPLICATION FOR VARIABLE LIFE TRANSACTIONS

Date	Insured's Name	First Name	Middle name	Surname	Contact No.
Policy Number	Owner's Name (if other than the Insured)	First Name	Middle name	Surname	Contact No.
Plan	Face Amount		Years to Pay		Mode of Payment

☐ **APPLICATION FOR TOP-UP PREMIUM**

Top-up Premium Amount _____ **Bank/APR/OPR Date and Number** _____

FUND ALLOCATION INSTRUCTION

Peso Plans

Guaranteed Fund (Max 90%)	=_____%
Peso Fixed Income Fund	=_____%
Peso Equity Fund	=_____%
Peso Bond Fund	=_____%
Others: _____	=_____%
TOTAL	**= 100%**

Dollar Plans

Guaranteed Fund (Max 90%)	=_____%
Dollar Bond Fund	=_____%
Others: _____	=_____%
TOTAL	**= 100%**

Agreement

1. The company reserves the right to require evidence of insurability on the Life insured satisfactory to us.
2. Top-up premium is considered only if regular premium has been fully paid.
3. If no Fund Allocation is specified, the existing Fund Allocation Instruction shall be applied.
4. Premiums are subject to the Company's current administration rules regarding minimum and maximum amounts.
5. Fund Allocation Instruction shall comply with the minimum allocation percentage in an Investment fund and maximum number of Investment Funds to which the premiums may be allocated as determined by the Company from time to time.
6. If you wish to apply this new Fund Allocation Instruction to all your succeeding transactions, please accomplish Application for Change of Fund Allocation Instruction.

HEALTH STATEMENT

Medically examined for this application? (If "Yes", give Medical Examiner's name.) ☐ No ☐ Yes Date Examined: _____

Since your last medical examination, non-medical declaration or health statement made in connection with the above policy:	Insured		Payor		Please give full details of any 'YES' answers
	Yes	No	Yes	No	
1. Have you had any illness, injury, hospital confinement, operation, treatment or have you consulted, or been examined by, or received advice from any doctor?					
2. Has there been any change in your health? If "Yes", specify current height and weight.					
3. Have you made any application for insurance / rein-statement which was declined, postponed or modified?					
4. Have you changed your occupation or has there been any change in your avocation (e.g. racing, scuba or sky diving)?					
5. Do you plan to go or work abroad soon? When? Where? Purpose and nature of work?					
6. (For women only) Are you pregnant? If so, how many months?					

I / we hereby declare that each of the above representations is true and correct and that I / we have fully stated all details of each 'Yes' answer.

I / we agree that the issuance, amendment or reinstatement applied for shall not be considered effected by reason of any payment made by me / us unless this application is actually approved by the Company during my / our lifetime and good health and until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied.

I / we agree that any payment made in connection with this application shall be considered as deposit only and shall not bind the Company until all other requirements for the issuance, amendment or reinstatement of said Policy are fully satisfied and until this application is finally approved by the Company during my / our lifetime and good health. If this application is disapproved, I / we also agree to accept the refund of all payments made in connection therewith, without interest, and to surrender the receipts for such payments.

I / we further agree that the issuance, amendment or reinstatement of said Policy, as granted by the Company upon this application, shall be contestable at any time within two years from this date of approval thereof, for fraud or misrepresentation of any material facts therein stated.

Dated at _____ on _____.

I/We, the undersigned Owner/Payor and/or Irrevocable beneficiary(ies) hereby certify that all statements and answers herein are true and correct. Also, I/We hereby certify that I/We carefully understood and agreed each and every agreement stated on this application form.

Right Thumbmark

(If unable to sign or if signature is in block letters)

_____
Signature of Agent/Witness

_____
Signature of Insured/Applicant/Payor

_____
Name of Agent/Witness (in Print)

_____
Signature of Irrevocable Beneficiary
(if age 18 & over)

_____
Code No. of Agent

_____
Signature of Irrevocable Beneficiary
(if age 18 & over)

With the consent of parent
(if Proposed Insured is below 18 yrs.):

_____
Signature above Printed Name

Right Thumbmark

(If unable to sign or if signature is in block letters)

For office use only