COCOLIFE

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

Application No. _____

Policy No. _____

APPLICATION FOR TOP-UP FOR VARIABLE LIFE INSURANCE

Date	POLICY OWNER First Name	Middle Name	Surname	Contact No.	Email Address:
(If other than the Policy Owner)	INSURED First Name	Middle Name	Surname	Contact No.	Email Address:

Policy Number	Plan	Face Amount	Years to Pay

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 Height: _____ Weigh: _____		Policy Owner Height: _____ Weigh: _____		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?					
3. Have you made any application for insurance / reinstatement 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 Top-Up 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 application for said Top-Up 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 of this Top-Up and its related Death Benefit, as provided in the Policy Contract, 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, subject to the Incontestability provision provided in the Policy Contract.

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.

Dated at _____ on _____ .

Left Thumbmark	Right Thumbmark

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

_____
Signature of Agent / Witness

_____
Signature of Insured / Policy Owner

_____
Name of Agent / Witness (In Print)

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

Left Thumbmark	Right Thumbmark

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

_____
Code of Agent

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

_

_

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

_____
Signature over Printed Name

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 (RA No. 10173 and its implementing Rules and Regulations (IRR)).

To enable us to perform our processes related with your amendment form, it is important that COCOLIFE collects, uses and stores your personal data. Thus, we are using your information to: (1) Evaluate the amended items provided; (2) Prevent Money Laundering or Terrorism Financing activities; (3) Comply with reportorial and regulatory requirements of law; and (4) Perform other reasonable purposes as may be necessary to implement the terms and conditions of the contract. When you provide information other than yours, you certify that you obtained their consent to disclose and process the information of your parents, spouse, children, dependent or about another person like stockholders, officers or 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 related parties e.g. any third-party service providers performing financial, administrative, technical and other ancillary services like credit investigation, and; person or entity that we contractually entered with, that ensures the confidentiality standard we implement and adhere 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 in 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 for purposes described in this Data Privacy Policy.

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

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. I/We hereby certify that I/ We carefully understood and comprehend the terms above before giving my/our consent.

_____
Name and Signature of Insured / Borrower

_____
Name and Signature of Policy Owner