

IMPORTANT NOTICE:

This form must be received by the Head Office by **3:00PM** on a business day, otherwise it shall be deemed to be received on the next business day.

GENERAL INFORMATION

Policy Owner: (Last Name, First Name, M.I.)	Policy Number:
Home Address:	Email Address:
Home Phone Number:	Mobile Phone Number:

Please indicate the fund and amount to be allocated:

FUND	AMOUNT

Notes:

- As of February 2018, the minimum top-up amount for:

Peso Single Pay Variable Life is	PhP 30,000.00 per policy
Peso Regular Pay Variable Life is	PhP 1,000.00 per policy
Dollar Single Pay Variable Life is	USD 1,000.00 per policy
- The top-up premium less charges including bank transaction charges, if any, will be used to purchase units at the applicable offer price of the fund (s) selected.

SHORT FORM OF DECLARATION OF INSURABILITY

If the insured answered "YES" to Questions 1, 2, 3, 4, 5, 6 please provide full details in the space provided. Please include physician's name and address, hospital, date and nature of consultation, sickness or impairment. Please use the back of this form, if necessary, and sign it. Etiqa Philippines reserves the right to request additional requirements based on the answers on the declaration form and evaluate accordingly the acceptability of the Insured thereafter.

1. Have you ever had or received treatment for diabetes, high cholesterol, high blood pressure, heart attack, stroke or any other heart or blood vessel disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Have you ever had or received treatment for Cancer or growth of any kind, any breast lump, or abnormality, breast examination, ultrasound or mammogram or an abnormal cervical smear test?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever had or received treatment for hepatitis, mental illness, epilepsy, HIV or AIDS or any disorder of the lungs, kidneys, liver or any other illness or physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Have you, within the last five (5) years, consulted any doctor and/or been advised to have any diagnostic test, hospital confinement or surgical operation or are you currently taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Do you participate or intend to participate in aviation (other than as a fare paying passenger), motor car or cycle racing, scuba diving or any other hazardous sport or activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. A. Do you drink alcohol? If Yes: Type _____ Quantity per day _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Have you ever used or injected yourself with any illegal or prohibited drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

7. Has your mother, or father or any brother or sister had diabetes, breast, cervical, ovarian, colon or other cancer, high blood pressure, heart problems, stroke, haemochromatosis, Huntington's disease, polycystic kidney, multiple sclerosis, Parkinson's or any other hereditary Yes No disease?

Family Member (Relationship to you)	Condition/Illness (For cancer/heart disease, specify type)	Age at onset of illness	Age at death (if applicable)
8. Present Weight	<input type="checkbox"/> Kg <input type="checkbox"/> Lbs	9. Present Height	<input type="checkbox"/> Ft <input type="checkbox"/> Cm
10. Will anyone other than the Insured/Owner be paying for this policy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

11. Has the Insured/Owner or any direct relative of either person ever held a senior position in the government, a political party, the military, any tribunal or government-owned corporation? Yes No

DECLARATION

1. I/We represent that the foregoing statements are true and complete and that all exceptions have been stated.
2. I/We authorize the Company to deduct, whenever applicable and appropriate, any bank and other transaction charges in addition to loading fees from top-up premium prior to investment.
3. I/We further agree that the above transaction shall be an amendment to and form part of the original application of the Policy issued thereunder, if any, and that it shall be binding on any person who shall have or claim any interest under such Policy/Agreement.
4. I/We agree that this request and any evidence of insurability which may be required in connection with the change requested shall be considered an essential amendment and supplement to the original application and shall form a part of the Policy, that if evidence of insurability is required, the change requested shall not be effective until it has been approved at the Home Office and the required additional premium has been actually paid and duly acknowledged.
5. In case of apparent errors or omissions discovered by the Company in the foregoing request, I/We hereby authorize Etiqua Philippines to correct or complete this request for amendment of the Policy and I/We agree that if the Policy/Agreement is changed in accordance with such amended request, my/our acceptance of any Policy/Agreement so amended or reissued will constitute my/our conformity to and ratification of any correction in or addition to this request made by the said Company in the space provided for.

Signature of Insured:	Printed Name:	Date of Signing: (mm/dd/yyyy)
Signature of Policy Owner (if other than Insured):	Printed Name:	Date of Signing: (mm/dd/yyyy)
Signature of Agent/Witness:	Printed Name:	Agent's Code:
Address of Agent/Witness		Unit Name:
Place of Signing:		Date of Signing: (mm/dd/yyyy)