

# Policy Amendment Request Form

Corporate/Entity Policyowner



PAC

**PRU LIFE INSURANCE CORPORATION OF U.K.**  
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## REMINDERS:

Please use **CAPITAL LETTERS** and **black ink**.  
Tick the appropriate box to indicate your choice.  
Please do not sign on a blank form.

One form for multiple policies may be used for:

- Minor amendment requests; and
  - Major amendment requests if the Policyowner, Life Insured, and Irrevocable Beneficiary/ies are all the same.
- Otherwise, the individual submission of Policy Amendment Request Form for each policy will be required.

POLICY NUMBERS


## DETAILS OF POLICYOWNER

COMPANY/BUSINESS NAME <input type="text"/>	NAME OF AUTHORIZED REPRESENTATIVE <input type="text"/>
COMPANY REGISTRATION NUMBER <input type="text"/>	MOBILE NUMBER OF AUTHORIZED REPRESENTATIVE <input type="text"/>
COUNTRY OF INCORPORATION <input type="text"/>	TELEPHONE NUMBER OF AUTHORIZED REPRESENTATIVE <input type="text"/>
DATE OF INCORPORATION (mm/dd/yyyy) <input type="text"/>	EMAIL ADDRESS OF AUTHORIZED REPRESENTATIVE <input type="text"/>

With changes in Policyowner's details in the records of Pru Life UK?

Yes (Fill out the additional KYC details section)

No

## DETAILS OF AMENDMENT REQUEST

### MINOR AMENDMENT

<b>1 ADDITIONAL KNOW-YOUR-CUSTOMER (KYC) DETAILS OF THE POLICYOWNER</b>	
If there are no changes in the following information, you may skip this section. Any information provided in this section will be used to update the Policyowner's details in our records.	
<b>DIRECTORS</b> (Please attach an updated General Information Sheet for the complete list of members of the Board of Directors.) <input type="text"/>	
<b>PRINCIPAL STOCKHOLDERS OWNING AT LEAST 2% OF THE GENERAL STOCK</b> (Please attach an updated General Information Sheet for the complete list of stockholders.) <input type="text"/>	
<b>BENEFICIAL OWNERS</b> (Individuals owning/controlling more than 25% of the company's shares or voting rights.) Please attach an updated General Information Sheet. <input type="text"/>	
<b>SUBSTANTIAL UNITED STATES (US) BENEFICIAL OWNERS</b> <input type="text"/>	
COMPANY TELEPHONE NUMBER <input type="text"/>	COMPANY MOBILE NUMBER <input type="text"/>
COMPANY EMAIL ADDRESS NUMBER <input type="text"/>	
NATURE OF BUSINESS <input type="checkbox"/> Financial institution <sup>1</sup> <input type="checkbox"/> Professionally managed trust <sup>2</sup> <input type="checkbox"/> Others <input type="text"/>	a) Is the Policyowner listed or traded on any regulated stock exchange? (If no, please complete question "b" below; otherwise, please ignore.) <input type="checkbox"/> Yes <input type="checkbox"/> No
<sup>1</sup> Financial institution refers to any organization that holds a banking, securities, and/or life insurance license. Examples of financial institutions include banks, life insurers, custodians, asset managers, and investment funds.	b) Does any USA person, entity, <sup>3</sup> directly or indirectly, own more than 10% of the organization? <input type="checkbox"/> Yes <input type="checkbox"/> No
<sup>2</sup> Professionally managed trust is a trust that is professionally managed by a bank, custodial institution, life insurance company, or investment entity that is a professional investment advisor.	<sup>3</sup> Defined as one of the following: a) citizen or resident of the USA; b) a partnership, corporation, company, or association created or organized in the USA or under the laws of the USA; c) any USA estate; d) any USA trust subject to USA supervision and substantially controlled by a USA person.
BUSINESS ADDRESS (number, street, municipality/city, province) <input type="text"/>	ALTERNATIVE ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as business address <input type="text"/>
COUNTRY <input type="text"/> ZIP CODE <input type="text"/>	COUNTRY <input type="text"/> ZIP CODE <input type="text"/>
<input type="checkbox"/> I warrant that the consent of the Beneficial Owner/s were obtained for the use, storage and processing of their information for purposes of compliance with regulatory requirements, the processing of the amendment applied for, and administration of the Policy/ies. I undertake to provide Pru Life UK with proof of my authority to give the required consents of the Beneficial Owner/s with respect to the disclosure and processing of their personal information and/or sensitive personal information for the legitimate purposes set out in this Policy Amendment Request Form or in the Policy/ies.	
<b>Preferred billing address of Policyowner for Pru Life UK correspondence:</b> <input type="checkbox"/> Insured's present address <input type="checkbox"/> Business address <input type="checkbox"/> Insured's permanent address <input type="checkbox"/> Alternative business address	
REASON FOR CHANGE IN ADDRESS (Note: If the new address is the same as the servicing agent's address, please indicate the relationship with the agent and reason for such request. This request is subject to further evaluation and approval in compliance with Pru Life UK guidelines.) <input type="text"/>	

## FOR OFFICIAL USE ONLY

BRANCH RECEIPT DETAILS	HEAD OFFICE RECEIPT DETAILS
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**DETAILS OF AMENDMENT REQUEST**

**2 CHANGE DETAILS OF LIFE INSURED**

Please fill out only the fields that need to be updated/changed.

SURNAME <input type="text"/>			MOBILE NUMBER <input type="text"/>		TELEPHONE NUMBER <input type="text"/>	
GIVEN NAME <input type="text"/>			EMAIL ADDRESS <input type="text"/>			
MIDDLE NAME <input type="text"/>			TIN <input type="text"/>		SSS/GSIS <input type="text"/>	
OTHER LEGAL NAME/ALIAS <input type="text"/>			OCCUPATION (State exact duties; if member of AFP/PNP, state rank) <input type="text"/>			
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Others <input type="text"/>		SALUTATION (e.g. Mr., Mrs., Miss, etc.) <input type="text"/>			
DATE OF BIRTH (mm/dd/yyyy) <input type="text"/>		AGE <input type="text"/>	NATIONALITY <input type="text"/>			
PLACE OF BIRTH (city/province, country) <input type="text"/>						
PRESENT ADDRESS (number, street, municipality/city, province) <input type="text"/>						
COUNTRY <input type="text"/>			ZIP CODE <input type="text"/>			
PERMANENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as present address <input type="text"/>						
COUNTRY <input type="text"/>			ZIP CODE <input type="text"/>			
EMPLOYER <input type="text"/>						
NATURE OF BUSINESS OF EMPLOYER <input type="text"/>						
EMPLOYER'S MOBILE NUMBER <input type="text"/>			EMPLOYER'S TELEPHONE NUMBER <input type="text"/>			
EMPLOYER'S EMAIL ADDRESS <input type="text"/>						
EMPLOYER/BUSINESS ADDRESS (number, street, municipality/city, province) <input type="text"/>						
COUNTRY <input type="text"/>			ZIP CODE <input type="text"/>			

**3 CHANGE IN BENEFICIARIES**

Accomplish this section only if there are changes in the Beneficiary Details.

Pru Life UK will assume the following default options unless stated otherwise: a) Beneficiary Designation – Revocable b) % Share – equal sharing among Beneficiaries

TYPE OF REQUEST  <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
	RELATIONSHIP TO INSURED <input type="text"/>	% SHARE <input type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	PLACE OF BIRTH <input type="text"/>		NATIONALITY <input type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner <input type="text"/>					COUNTRY <input type="text"/>		ZIP CODE <input type="text"/>
TYPE OF REQUEST  <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
	RELATIONSHIP TO INSURED <input type="text"/>	% SHARE <input type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	PLACE OF BIRTH <input type="text"/>		NATIONALITY <input type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner <input type="text"/>					COUNTRY <input type="text"/>		ZIP CODE <input type="text"/>
TYPE OF REQUEST  <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	
	RELATIONSHIP TO INSURED <input type="text"/>	% SHARE <input type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable	PLACE OF BIRTH <input type="text"/>		NATIONALITY <input type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner <input type="text"/>					COUNTRY <input type="text"/>		ZIP CODE <input type="text"/>

Please use the special instructions box below if there are more than three (3) Primary and/or Secondary Beneficiaries.

<b>SPECIAL INSTRUCTIONS</b> <input type="text"/>
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**DETAILS OF AMENDMENT REQUEST**

**4 CHANGE METHOD OF PAYMENT**

Cash  Post-dated check

**5 RESUME CREDIT CARD/AUTO-DEBIT ARRANGEMENT (ADA) BILLING**

I, as the Authorized Representative, opt to resume credit card/ADA billing and allow Pru Life UK to collect all unpaid premiums from the most recent enrolled/existing card of the Policyowner.

**6 STOP CREDIT CARD/AUTO-DEBIT ARRANGEMENT (ADA) BILLING**

I, as the Authorized Representative, opt to stop credit card/ADA billing and agree to the following conditions:  
Request must be received by Pru Life UK at least five (5) working days before the premium due date. All unpaid premiums shall be collected upon resumption of the billing. To prevent lapsation of the Policy/ies, the Policyowner may select from Pru Life UK's other auto-pay facilities, ADA, and Post-Dated Check (PDC).

**7 CHANGE MODE OF PAYMENT**

Annual  Semi-annual  Quarterly  Monthly

**8 PREMIUM HOLIDAY AVAILMENT**

I, the Authorized Representative, opt to avail of the Premium Holiday. Premium payments may be discontinued at any time, as long as the fund value is sufficient to cover the applicable charges on the Policy/ies. Once the fund value is insufficient to cover the said outstanding charges, the Policy/ies will be terminated.  
If this feature is availed of, corresponding charges will be applied (applicable for Elite plans).

**9 NON-FORFEITURE OPTION (FOR TRADITIONAL PLANS ONLY)**

Cash surrender value  Reduced paid-up insurance  Automatic premium loan option  Extended term insurance

**10 DIVIDEND OPTION AND SUB-OPTION (FOR TRADITIONAL PLANS ONLY)**

Paid in cash  Used to pay a portion of premium  Used to buy paid-up insurance  Left to accumulate and earn interest sub-option:  
 Ordinary accumulation  
 Self-liquidation  
 Fully paid-up  
 Early maturity  
 Cash allowance

**11 DIVIDEND CONSENT (FOR TRADITIONAL PLANS ONLY)**

I, the Authorized Representative, agree to use any dividend accumulation of the Policy/ies towards any premium default option in effect.

**MAJOR AMENDMENT**

**12 PREMIUM**

Increase  Decrease Amount:

**13 SUM ASSURED**

Increase  Decrease Amount:

**14 RIDERS**

TYPE OF REQUEST	NAME OF RIDER	RIDER COVERAGE
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		

Please use the special instructions box below if there are more than ten (10) riders.

**SPECIAL INSTRUCTIONS**



## DETAILS OF AMENDMENT

### 15 RECONSIDERATION OF RATING

- Health
- Submission of medical documents is required.
  - The Policyowner will shoulder the expenses for medical examinations.
  - Request is subject to the approval of Pru Life UK.
- Occupation
- Completely fill out the "Change in Occupation" details.
  - A Certificate of Employment from the Life Insured's new employer is required.

#### CHANGE IN OCCUPATION DETAILS

NEW OCCUPATION  NATURE OF WORK OR NATURE OF BUSINESS (if self-employed)

EMPLOYER

NATURE OF BUSINESS OF EMPLOYER

EMPLOYER/BUSINESS ADDRESS (number, street, municipality/city, province)

COUNTRY

ZIP CODE

JOB DESCRIPTION

#### SPECIAL INSTRUCTIONS

## STATEMENT OF INSURABILITY

This section should be completed and signed by the Life Insured for any increase in insurance coverage, inclusion of riders, or any request involving additional risks.

	Life Insured	Details
1. Are you in good health, free from all diseases, deformities and abnormalities? If no, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Since the issuance of the Policy/ies or the last reinstatement, have you:		Details of "YES" answer
a) Ever had any illness or recurrent illness, injury, medication, or disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Ever had any medical consultation, hospitalization, or surgical operation due to any condition, or been prescribed for or attended by a physician or practitioner for any cause, or undergone any diagnostic test/s? Please indicate results.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Ever been confined or hospitalized in a clinic, institution, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d) Ever changed your customary occupation, or country of residence? If yes, please indicate details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e) Ever had any application for life, accident or health insurance, or reinstatement that was declined, postponed, rated, or modified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f) Experienced death among the immediate members of your family? If yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. For female clients, are you now pregnant? If yes, how many months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

## AUTHORIZATION TO FURNISH MEDICAL INFORMATION

In order to be able to process this request, the Policyowner and/or Life Insured authorize PRU LIFE INSURANCE CORPORATION OF U.K. and its authorized representatives, including its investigators, to obtain the relevant medical information from hospitals, medical facilities, and physicians. A photocopy of this authorization shall be deemed as valid as the original.

## SUBSTITUTE DECLARATION STATEMENT

- Tick if statement below is applicable
- I, the Authorized Representative, declare that the Policyowner is not one of the following:
- Financial institution;
  - Professionally managed trust;
  - Non-listed entity of which more than 10% is owned by any USA person/entity; or
  - Required to file a tax return in the USA.



**DECLARATION OF UNDERSTANDING**

**PLEASE READ CAREFULLY BEFORE SIGNING THE POLICY AMENDMENT REQUEST FORM:**

By signing this Policy Amendment Request Form ("Form"), I (i.e. each of the Policyowner/Authorized Representative, Life Insured, and the Irrevocable Beneficiary/ies, if any) declare, agree to, and authorize the following:

1. All the statements and answers in this Form and any information given to Pru Life UK or its medical examiners, including any amendments, are complete, true, correct and binding on all parties in interest under the Policy/ies.
2. Pru Life UK reserves the right to request for additional medical evidence to assess my health. Any physician, hospital, clinic or medical organization is authorized to furnish Pru Life UK with any medical information pertaining to me.
3. Prior to the approval of the amendment of the Policy/ies applied for, I agree to inform Pru Life UK of any change in my (a) state of health, and (b) occupation or activities.
4. I will update Pru Life UK in a timely manner of any change in details previously provided especially with respect to a change in citizenship, tax status or tax residency. If the Policyowner is a corporation, changes in registered address, address of place of business, substantial shareholders, legal or beneficial owners who own or control more than 25% of the Policyowner will also be disclosed. If any of these changes occurs or if any other information comes to light concerning such changes, I agree to provide additional documents or information as may be requested by Pru Life UK, including but not limited to duly completed and/or executed (and, if necessary, notarized) tax declarations or forms.
5. This application is subject to the guidelines on anti-money laundering and financial underwriting. Pru Life UK can disapprove this application or terminate the Policy/ies if I fail to provide the necessary information relating to this application or relevant transaction or if this application violates the said guidelines.
6. I fully understand and accept the consequences of the amendment requested hereunder.
7. I agree to receive financial and other policy related information through the mobile number and email address provided to Pru Life UK. Pru Life UK shall not be liable for claims or liabilities incurred as a result of the dissemination of personal information through said facilities.
8. I understand that Irrevocable Beneficiary/ies is/are given equal rights over the Policy/ies as the Policyowner. I, as the Policyowner, cannot exercise any of my rights under the Policy/ies without the consent and signature of all Irrevocable Beneficiary/ies. Such rights include but are not limited to decrease or deletion of any benefit or the change, addition or deletion of beneficiaries.
9. I understand that I must submit this form within three (3) months from the date of signing.

**DATA PRIVACY**

For purposes of this Section:

- a. "Pru Life UK" shall refer to Pru Life Insurance Corporation of U.K., its directors, officers, employees, insurance agents, insurance brokers, other agents and representatives, reinsurers, contractors, legal advisers, and Pru Life Insurance Corporation of U.K.'s subsidiaries, affiliates and other related entities, and their directors, officers, employees, insurance agents, insurance brokers, other agents and representatives, contractors and legal advisers.
  - b. "Data subject" shall mean any or all of the Policyowner, the Life Insured, the Beneficial Owner, Beneficiary/ies, and all other individuals whose personal information or sensitive personal information is or will be disclosed to Pru Life UK for processing, which may either be manual or automated, in relation to the issuance, implementation and handling of insurance policies, direct marketing, profiling, risk assessment, underwriting and administration of insurance coverage and claims, data analytics, and data sharing with Pru Life UK.
1. I hereby consent to the manual or automated processing of my personal information and/or sensitive personal information by Pru Life UK, within or without the Philippines, in accordance with the Data Privacy Act and its implementing rules and regulations and the publicly available Pru Life UK privacy policy found in the company website at www.prulifeuk.com.ph, for the purposes deemed fit by Pru Life UK, which shall include issuance, implementation and handling of insurance policies, direct marketing, profiling (which includes product and other offers), risk assessment, underwriting and administration of insurance coverage and claims, data analytics, and data sharing with Pru Life UK.
  2. I hereby authorize Pru Life UK to disclose my particulars or any information to any Authority (governmental and other regulatory authority or self-regulatory body in various jurisdictions) in connection or adherence (whether voluntary or otherwise) with Applicable Requirements (laws, regulations, orders, guidelines, codes, market standard, good practices and requests of or agreements with any Authority as promulgated and amended from time to time). Such disclosure may be effected directly or sent through any of Pru Life UK's Head Office(s) or other related corporations, or in such manner as may be deemed fit. For purposes of the foregoing and notwithstanding any other provision in this Form or any other agreement between the parties, Pru Life UK may need me to provide further information or documents as may be required for disclosure to any Authority and I shall provide the same within such time as may be reasonably required. I hereby consent to the use and transfer of my particulars under Republic Act No. 10173, the Data Privacy Act of 2012, the Anti-Money Laundering Act of 2001, the E-Commerce Act of 2000, the Philippine AIDS Prevention and Control Act, the Magna Carta for Disabled Persons, Presidential Decree No. 1718, Credit Information System Act, and any other applicable data protection legislation from time to time in force ("Data Privacy Laws").
  3. Pru Life UK, its duly authorized processors such as but not limited to contractors for services providing anti-money laundering systems, claims investigation, photocopy and scanning, courier, and printing, and reinsurers are allowed to use, collect, store and process the personal and sensitive personal information obtained by Pru Life UK pursuant to this Form or the Policy/ies for legitimate purposes such as underwriting and administration of insurance coverage and claims and processing of after-sales transactions. Any such information collected may be retained by the aforementioned parties until ten (10) years from the date of maturity or termination of the Policy/ies or date of denial of this request or application, whichever comes earlier.
  4. I warrant that the consent of the Beneficial Owner (if any), Beneficiary/ies and all other data subjects were obtained for the use, storage and processing of their information for purposes of compliance with regulatory requirements, the processing of this Form and administration of the Policy/ies and I undertake to provide Pru Life UK with proof of my authority to give the required consents of the other data subjects with respect to the disclosure and processing of their personal information and/or sensitive personal information for the legitimate purposes set out in this Form or in the Policy/ies.
  5. I understand that prior to the passage of data privacy legislation in the Philippines, particularly Republic Act No. 10173, otherwise known as the "Data Privacy Act of 2012", life insurance companies have already shared information, including mine, among themselves through an existing Medical Information Bureau (MIB) administered by the Philippine Life Insurance Association (PLIA). The sharing of medical information was done in order to enhance risk assessment and prevent fraud.  
In accordance with the Insurance Commission's Circular Letter No. 2016-54, I understand that my medical information, including those previously collected by the MIB, will be uploaded to a Medical Information Database accessible to life insurance companies. Once uploaded, all life insurance companies will 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.
  6. I will indemnify Pru Life UK and hold it free and harmless for any damages incurred by Pru Life UK as a result of any claim filed by any of the data subjects in relation to a breach of any of the warranties above, or for any damages arising from any misrepresentation made in this Form or from any material breach of its provisions.

EXECUTED AT  PLACE THIS         DATE COMPLETED (mm/dd/yyyy)

✓ Signature over printed name of **POLICYOWNER/AUTHORIZED REPRESENTATIVE**

✓ Signature over printed name of **LIFE INSURED**

✓ Signature over printed name of **IRREVOCABLE BENEFICIARY/IES/ASSIGNEE**

✓ Signature over printed name of **WITNESS**

✓ Signature over printed name of **IRREVOCABLE BENEFICIARY/IES/ASSIGNEE**

✓ Signature over printed name of **IRREVOCABLE BENEFICIARY/IES/ASSIGNEE**



**CERTIFICATION OF CUSTOMARY SIGNATURE FOR POLICYOWNER/AUTHORIZED REPRESENTATIVE**

This is to certify that I am the same person who signed the Application for Life Insurance. I confirm that the declarations and information therein were given by me personally and that they are true and complete to the best of my knowledge.  
Finally, I certify that the signature appearing on all my forms and valid IDs is my customary signature, as follows:

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**CERTIFICATION OF CUSTOMARY SIGNATURE FOR IRREVOCABLE BENEFICIARY/IES**

Full name of Irrevocable Beneficiary 1:			
Full name of Irrevocable Beneficiary 2:			
Full name of Irrevocable Beneficiary 3:			

