



Please fully accomplish this form to facilitate processing of your request.

INSURED'S NAME (Please print) _____
 MAILING ADDRESS _____
 TELEPHONE NUMBER _____
 MOBILE NUMBER _____

Policy No. _____ Agent's Name _____
 Document Enclosed Health Statement Agent's Code _____
 Policy Contract Payment: P _____
 Others _____ CR# _____ Date _____

REQUEST	PARTICULARS			
<input type="checkbox"/> Change name/date of birth <input type="checkbox"/> Insured <input type="checkbox"/> Owner (Attach birth certificate, marriage contract or other legal documents)	New Name _____ Former Name _____		Reason <input type="checkbox"/> Marriage to _____ on _____	
	Date of Birth _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Correction <input type="checkbox"/> Legal Separation <input type="checkbox"/> Others _____	
<input type="checkbox"/> Change Mode of Payment	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly – SMPDC <input type="checkbox"/> Monthly – SA No. _____ (Enclose authorization form) Effective _____			
<input type="checkbox"/> Change beneficiary designation <input type="checkbox"/> Inclusion <input type="checkbox"/> Deletion Note: 1. If more than one beneficiary is named in any class, equal shares shall be assumed unless otherwise specified. 2. If beneficiary designation is irrevocable, the written consent of the beneficiary is required. 3. If irrevocable beneficiary is a minor, legal guardianship is required.	Beneficiary	Name	Age	Relationship
	<input type="checkbox"/> Primary <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable			
	<input type="checkbox"/> Contingent <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable			
<input type="checkbox"/> Non-forfeiture Option	<input type="checkbox"/> Reduced Paid-up Insurance Effective _____ <input type="checkbox"/> Extended Term Insurance			
<input type="checkbox"/> Change Dividend Option	<input type="checkbox"/> Option 1 – Pay in Cash <input type="checkbox"/> Option 3 – Accumulate with Interest <input type="checkbox"/> Option 2 – Reduce Premium <input type="checkbox"/> Option 4 - Purchase Paid -up Additions			
<input type="checkbox"/> Change Plan/Riders/Face Amount (Attach Policy Contract and Health Statement except for reduction of amount and deletion of riders)	<input type="checkbox"/> Plan _____ <input type="checkbox"/> Face Amount _____ <input type="checkbox"/> Addition of Riders _____ <input type="checkbox"/> Deletion of Riders _____			
<input type="checkbox"/> Change Effective Date (Allowed only once)	<input type="checkbox"/> Reinstatement by Redating <input type="checkbox"/> Redate to _____			
<input type="checkbox"/> Remove/Reduce Rating (Attach Policy Contract and Health Statement)	<input type="checkbox"/> Medical Rating <input type="checkbox"/> Occupational Rating New Occupation _____ since (date) _____			
<input type="checkbox"/> Term Conversion	<input type="checkbox"/> Attained Age <input type="checkbox"/> Amount Converted _____ <input type="checkbox"/> Original Issue Age <input type="checkbox"/> New Plan _____ <input type="checkbox"/> Converting Agent _____			
<input type="checkbox"/> Others (Please specify)				

I/We hereby agree that should request be approved by the company, such request shall, from the date of such approval, amend in accordance with the terms thereof so approved the contract contained in the policy to which the request refers.

Signed on _____, ____ at _____

Witness/Agent Name & Signature
 Agent

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Signature of Insured _____
 Signature of Owner/Assignee/Irrevocable Beneficiary _____

FOR OFFICE USE ONLY

REMARKS

APPROVED BY _____ Date _____

OFFICE _____

HOME OFFICE ENDORSEMENT

Note: PLEASE ATTACH THIS FORM TO YOUR POLICY TO FORM PART THEREOF