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

TYPE OF LOAN
☐ 1. New Loan
☐ 2. Additional P _____
☐ 3.Renewal
Details of previous loans, Additional and Renewal should be completely filled out. (all loans should be included)

Amount of Loan	Effective Date	Term of Coverage

* For additional list of previous bans, kindly us the back page of the application form.
NOTE: If the total loan amount is beyond the non-medical limit, the premium payments are only considered as premium deposit. The client shall undergo medical examination if his/her total sum assured exceeds the non-medical limit.

APPLICATION FOR GROUP CREDIT LIFE INSURANCE

_____
(NAME OF POLICYHOLDER/CREDITOR)
GROUP POLICY NO. _____

I. APPLICANT'S PERSONAL DATA

FULL NAME: LAST NAME	FIRST NAME	MIDDLE NAME		
PERMANENT ADDRESS:			HEIGHT:	WEIGHT:
PRESENT ADDRESS:			CIVIL STATUS:	SEX:
DATE OF BIRTH:	PLACE OF BIRTH:	NATIONALITY:	TIN:	SSS/GSIS NO.:
EMAIL ADDRESS:	ALTERNATE EMAIL ADDRESS:	CONTACT NO.:	ALTERNATE CONTACT NO.:	
OCCUPATION/POSITION	NATURE OF WORK/JOB DESCRIPTION/NATURE OF BUSINESS			
EMPLOYER/BUSINESS NAME	EMPLOYER/BUSINESS ADDRESS	EMPLOYER/BUSINESS TELEPHONE NUMBER		
IF SEAMAN, PORT OF ENTRY?	IF WORKING ABROAD, IN WHICH COUNTRY?			
NAME OF SPOUSE	SPOUSE OCCUPATION			

BENEFICIAL OWNER. It refers to any natural person who ultimately owns or controls the customer, and/or on whose behalf a transaction or activity is being conducted, or has ultimate control over a legal person or arrangement. In relation to a juridical entity, Beneficial Owner/s are individuals either owning or controlling at least 20% or more of the company's shares or voting rights.

Do you have a Beneficial Owner? ☐ YES ☐ NO
If "YES", please accomplish the Certification for Beneficial Owner Form.

PART II. SOURCE OF FUNDS (If the applicant will pay the premium in part or in full)

SOURCE OF FUNDS
☐ Salary / Professional Fees / Commission ☐ Savings ☐ Business Others (Please specify): _____

PART III. BENEFICIARIES (Share equally unless otherwise stated. Use another form for additional beneficiaries)

FULL NAME	DATE OF BIRTH (mm/dd/yyyy)	PLACE OF BIRTH	SEX	RELATIONSHIP	SHARE	DESIGNATION	
						Primary **(P)** Contingent **(C)**	Revocable **(R)** Irrevocable **(I)**
1.							
2.							
3.							
4.							
5.							

Numbering doesn't indicate hierarchy of Beneficiaries

(Continuation)

	Nationality	Address	Contact Details (Mobile and/or Email)
1.			
2.			
3.			
4.			
5.			

NOTE: All beneficiariy designations are deemed "Primary" and "Revocable" unless indicated otherwise

IV. HEALTH DECLARATION

I hereby warrant and declare to the best of my knowledge that on the date of the release of my loan, I am currently well and possess sound health and am able to perform the usual activities in the pursuit of my livelihood and that:

1. I am in good health and entirely free from any mental or physical impairments or deformities.
2. I have not suffered or do now suffer from: a.) disease of the circulatory system (e.g. heart trouble, rheumatic fever, high blood pressure, disease of the arteries and veins); b.) disease of the respiratory system (e.g. tuberculosis, asthma, persistent cough, pneumonia); c.) disease of the genito-urinary system (e.g. infections of the kidneys, urinary or genital organs, renal stones, venereal disease); d.) disease of the gastro-intestinal system (e.g. digestive disorders, gastric or duodenal ulcer, hepatitis B or other disorders of the liver, disorders of the gall bladder); e.) diseases of the nervous system or mental disorders (e.g. epilepsy, fits or fainting attacks, frequent headaches, nervous breakdown); f.) diabetes, cancer, or any disease of the blood, glands, spleen, ears, eyes or skin; g.) unexplained night sweat and/or loss of weight, persistent fever, chronic or recurrent diarrhea, unexplained infections, swollen glands; h.) any other diseases or ailments not mentioned above.
3. I never had or been advised to have hospital treatment or surgery.
4. I never had or been advised to have a blood test for AIDS or any AIDS-related condition or have ever been refused as blood donor.
5. I have not consulted a physician for any reason, including routine examinations and blood tests or have received blood transfusions within the past five (5) years.
6. I have not received or now receive disability benefit.
7. I have not applied for insurance which was declined, postponed or modified in plan or rate for any life or disability insurance.
8. For WOMEN only: I am not pregnant.

EXCEPTIONS TO THE ABOVE: (if left blank, this will be taken to mean as "NONE" _____

* In as much as I cannot read, write or understand the language, before I affix my thumbmarks (duly witnessed) to this application, it has been read and translated to me by my Creditor's authorized officer or representative.

V. AUTHORIZATION TO FURNISH MEDICAL/OTHER RELATED INFORMATION

I hereby authorize any physician, medical practitioner/provider, clinic, hospital, or other medically-related facility, insurance company, government or private office or other person, organization, or institution that has any record or knowledge of my Medical/Health History and any information related thereto, to give to COCOLIFE or its HO Underwriter, Medical Director, or any named-representative, any such information/records.

This information pertains to all records containing medical or non-medical data including, but not limited to, mental and dental care, drug or alcohol use, prescribed drugs, information about communicable diseases which include, but not limited to, human immunodeficiency virus (HIV), acquired immunodeficiency virus (AIDS) and AIDS related complex (ARC), and any employment and insurance coverage information. Also, I hereby authorize COCOLIFE to obtain an investigative report from a duly authorized inspection agency which will provide any applicable information concerning my character, general reputation, personal characteristics, mode of living, health and financial status through interviews with friends, neighbors, and associates; and to obtain and make a brief report regarding my insurability to the Medical Information Database (MID), which operates as an information exchange with other Life Insurance Companies.

This authorization is in connection with my application for insurance and/or any insurance claim that may arise therefrom.

By affixing my signature below, I hereby declare that: (a) I have read and understood the foregoing health declarations including the "exceptions to the above" portion; (b) The foregoing 'statement and answers are full, complete and true; and (c) I agree that they shall be the basis of the issuance of insurance for me under the Group Policy and COCOLIFE shall not be liable for any claim on account of illness, injury, or death, the cause of which was known prior to approval of my request for insurance and withheld or concealed in the above statements.

PART VI. FOREIGN ACCOUNT TAX COMPLIANCE ACT ("FATCA")

Insured	Owner	
☐	☐	You acknowledge that you are a United States ("U.S.") Person[1] under U.S. Laws
☐	☐	You acknowledge that you are NOT a U.S. Person under U.S. Laws
☐	☐	But you have at least one of the following U.S. Indicia[2]
☐	☐	And you have no U.S. Indicia

***** You agree to advise us as soon as possible of any change in the information that you provided to us.*****

[1] U.S. Person means: a) U.S. citizen (including dual citizens); b) U.S. permanent resident (green card holders); c) Individual that have stayed for a substantial number of days in the U.S. (ie. More than 31 days during the current year or a total of 183 days during the 3-year period that includes the current year and the 2 years immediately before that) d) U.S. corporations, partnerships, and trusts created under U.S. law; or e) Foreign (non-U.S. registered) entities that are substantially owned by a U.S. Person (more than 10% of the entity by vote or value)

[2] a) U.S. Place of Birth; b) U.S. mailing or residence address (including a U.S. post office box) c) U.S. telephone number; d) A standing instruction to transfer funds to an account maintained in the United States; e) A currently effective power of attorney or signatory authority granted to a person with a U.S. address; or f) An "in-care-of" or "hold mail" address that is your sole address.

VII. 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 application for life and other various products, it is important that COCOLIFE collects uses and, stores your personal data. Thus, we are using your information to:

1. Administer your policy, with any person or organization who has information about you, including your employer/creditor under Group Accounts, authorized institutions, investigative agencies, insurers and reinsurers;
2. Prevent Money Laundering or Terrorism-Financing activities; and
3. Perform any other action as may be necessary to implement the terms and conditions of our contract.

When you provide information other than yours, you certify that you obtained their consent to disclose and process those information of your parents, spouse, children, dependent or about another person like stockholders, directors, 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. employer under Group Accounts for related purpose provided in the policy; any third-party service providers performing financial, administrative, technical and other ancillary services, and; person or entity that we contractually entered with, that ensures the confidentiality standard we implement and adheres 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.

VIII. CONSENT

During the effectivity of the contract/policy, I agree to the following: (1) In case the Company is unable to comply with relevant customer due diligence (CDD) measures, as required under the Anti-Money Laundering Act, as amended and relevant issuances, due to the fault of the client, the Company may: (a) impose measures to restrict the services available or prohibit any further transactions on the contract policy until full and proper CDD measures have been successfully conducted; and (b) in case the foregoing is unsuccessful, the Company may terminate business relationship. The exercise of the company of this measure shall only entitle the client/ customer to receive the unused portions of premium or withdrawal value, if any, whichever is applicable; and (2) Be bound by obligations set out in relevant United Nations Security Council Resolutions relating to the prevention and suppression of proliferation financing of weapons of mass destruction, including the freezing and unfreezing actions as well as prohibitions from conducting transactions with designated persons and entities.

I, the undersigned hereby certify that I explicitly and unambiguously consent to the collection, processing, sharing, storing of your personal and sensitive personal information by COCOLIFE for purposes described in the Data Privacy Policy and FATCA. I hereby certify that I carefully understood and comprehend the terms above before giving my consent.

Signed at : _____ this _____ day of _____ 20_____.

Witnessed and issued by:

_____
Creditor's Authorized Officer
*Signature Over Printed Name

_____
Signature of Applicant

Right Thumb mark

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

Left Thumb mark

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