

## APPLICATION FOR TRANSFER OF OWNERSHIP WITH TRANSFER AGREEMENT

DETAILS OF ORIGINAL PLAN (To be filled-out by the Transferor)				
ORIGINAL PLAN HOLDER'S NAME (Please print)		PLAN NUMBER		LOT TYPE/ID NO. (If Any)
BIRTHDATE (MM/DD/YYYY)	NATIONALITY	PRODUCT NAME	PAYING PERIOD	MATURITY PERIOD
TELEPHONE NO. (Please include AREA CODE) ( )	MOBILE NUMBER	EMAIL ADDRESS		NOMINEE'S NAME & AGE AT ISSUE (For Education)
MAILING ADDRESS				
REASON FOR TRANSFER			TRANSFEROR'S SIGNATURE	

Document/s Enclosed: (All documents must be submitted in order for transfer of ownership to be processed and approved by PhilPlans)

Original Policy Contract    Original Certificate of Full Payment    Processing Fee (Non-Refundable) OR No. \_\_\_\_\_ OR Date \_\_\_\_\_

### PERSONAL INFORMATION OF THE TRANSFEREE

(Accomplishment of this form by the Transferee shall be treated by PhilPlans as compliance with the Application Form required in the Plan Agreement)

FIRST NAME		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		HONORIFIC <input type="checkbox"/> MR <input type="checkbox"/> MISS <input type="checkbox"/> MRS <input type="checkbox"/> Others: _____	
MIDDLE NAME		CIVIL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		SPOUSE (For Married Transferee) Name: _____ Date of Birth _____ Cellphone No. _____	
LAST NAME		CITIZENSHIP (if Non-Filipino, please specify) PLANHOLDER _____ SPOUSE _____			
DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	MOTHER'S MAIDEN NAME (FIRST NAME, MIDDLE NAME, LAST NAME)			
SOURCE OF INCOME	ESTIMATED ANNUAL INCOME	IDENTIFICATION TYPE (WITH PICTURE) <input type="checkbox"/> UMID <input type="checkbox"/> SSS <input type="checkbox"/> GSIS <input type="checkbox"/> PASSPORT <input type="checkbox"/> DRIVER'S LICENSE <input type="checkbox"/> OTHERS (Please specify) _____		ID NUMBER	

**OCCUPATION (EXACT DUTIES / POSITION)**

PRIMARY OCCUPATION : \_\_\_\_\_ COMPANY NAME : \_\_\_\_\_

PLACE OF WORK : \_\_\_\_\_ NATURE OF BUSINESS : \_\_\_\_\_

CONTACT DETAILS	CURRENT ADDRESS (No., St., Brgy, City, Province, Country, Zip Code)	PERMANENT ADDRESS (No., St., Brgy, City, Province, Country, Zip Code)
TELEPHONE NO. _____		
CELLPHONE NO. _____		
EMAIL ADDRESS _____		

**BENEFICIARIES: (IF NAMED BENEFICIARY BELOW IS BELOW 18 YEARS OLD, PLEASE INDICATE GUARDIAN)**

BENEFICIARY/IES	NAME (FIRST NAME/MIDDLE NAME/LAST NAME)	DATE OF BIRTH (MM/DD/YYYY)	AGE	RELATIONSHIP TO TRANSFEREE
1 PRIMARY				
2 SECONDARY				
3 GUARDIAN (if applicable)				
NOMINEE (For Education Plan Only)				

Note: <sup>1</sup>All listed Primary Beneficiaries shall get equal share of benefits unless otherwise specified.

<sup>2</sup>Any payment made to the Guardian of any amount payable to the beneficiary while such beneficiary/ies is/are still below age 18 shall discharge PhilPlans from any further liability under the plan contract.

**FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) QUESTIONS**

<input type="checkbox"/> YES <input type="checkbox"/> NO ► Are you a U.S. Citizen? <input type="checkbox"/> YES <input type="checkbox"/> NO ► Are you a tax resident of the U.S because you hold a green card (permanent resident card)? <input type="checkbox"/> YES <input type="checkbox"/> NO ► Are you a tax resident of the U.S. under substantial presence test? <small>(To meet the test you must be physical present in the U.S. for at least (a) 31 days during the current year, and (b) 183 days during the 3 years period that includes the current year and the two (2) years immediately before that counting: 1) All days you were present in the current year, 2) 1/3 of the days you were present in the first year before the current year, and 3) 1/6 of the days you were present in second year before the current year.)</small>	<b>FOREIGN TIN/SSN</b>  
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**HEALTH INFORMATION OF THE TRANSFEREE (ONLY FOR PLANS WITH INSURANCE BENEFITS)**

I would like to apply for <input type="checkbox"/> WITH Insurance Benefit <input type="checkbox"/> NO insurance Benefit		DETAILS OF YES ANSWERS MUST INCLUDE DATE, DIAGNOSIS, DURATION OF ILLNESS, RESULT OF TREATMENT OR TEST DONE AND NAMES/ADDRESSES OF ATTENDING PHYSICIANS AND MEDICAL FACILITIES.
PRESENT HEIGHT <input type="text"/> <input type="checkbox"/> ft <input type="checkbox"/> cm	PRESENT WEIGHT <input type="text"/> <input type="checkbox"/> lbs <input type="checkbox"/> kgs	
<b>YES</b>	<b>NO</b>	<b>DECLARATION AND REPRESENTATIONS</b>
		Is the applicant not below 18 or over the acceptable age as specified in the contract of the plan being applying for?
		During the past years, has the applicant consulted a physician for medical treatment, had any laboratory or other diagnostic test or sought medical advice for treatment or been confined in a hospital, clinic or similar institutions?
		Has the Applicant ever taken habit-forming drugs, alcoholic drinks or smoked cigarettes? (If YES, please specify and indicate amount/portions, frequency and durations/length of time.
		Does the Applicant have any abnormality or impairment in his health or physical conditions?
		Has the Applicant ever engaged in motor sports, parachuting, and underwater driving?

It is understood and agreed that the issuance and continuance of the insurance on this application are based on the truth of the foregoing representations, and are subject to the provisions of the Group Life Insurance Policy/Policies issued by the Insurance Company/ies to PHILPLANS FIRST, INC. ("PhilPlans").

I hereby authorize any physician, hospital, clinic and insurance company or other organization, institution or person, that has any record or knowledge of me, to give PhilPlans any and all information about me with reference to my health, medical history, confinement, advice, diagnosis, treatment, disease or ailment, and driving history. This authorization is made in connection with this transfer of ownership application. I hereby agree that a photographic copy of this authorization shall be as valid as the original. **I agree that if I am not insurable, the Plan will be transferred to me without the insurance coverage, if any**

\_\_\_\_\_  
WITNESS / TRANSFEROR  
SIGNATURE OVER PRINTED NAME

\_\_\_\_\_  
TRANSFEREE  
SIGNATURE OVER PRINTED NAME

# TRANSFER AGREEMENT

For valuable consideration received, I, \_\_\_\_\_ (the "Transferor"), a \_\_\_\_\_ citizen, of legal age, and residing at \_\_\_\_\_ Philippines, do hereby cede, transfer, and assign all of my rights, interests and privileges in and to Plan Contract No. \_\_\_\_\_ with plan specifications detailed above (the "Plan") issued by PhilPlans First, Inc. ("PhilPlans") to \_\_\_\_\_ (the "Transferee"), \_\_\_\_\_ citizen, of legal age, and residing at \_\_\_\_\_, Philippines, in accordance with the following terms and conditions:

- Effectivity of Transfer.** The parties hereby acknowledge that the transfer of the Plan from the Transferor to the Transferee shall not take effect until the transfer is recorded and approved by PhilPlans and a new Plan Contract is issued by PhilPlans to the Transferee. Pending the approval of the transfer of the Plan by PhilPlans, all rights and benefits thereunder shall remain with and be payable to the Transferor. PhilPlans reserves the right to withhold or refuse the assignment of the Plan only if such transfer will unduly prejudice PhilPlans or expose it to litigation or administrative penalty.
- Release from Liability.** Upon approval of the transfer of the Plan, the Transferor shall cease to have any rights, interests and privileges in and to the Plan and PhilPlans shall be released from any and all liabilities and obligations to the Transferor in relation to the Plan.
- Counterparts.** This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Any single counterpart or set of counterparts signed in either case by any of the parties hereto shall constitute a full and original agreement for all purposes.

I hereby certify and warrant that I have full authority to cede, transfer, convey and assign the Plan and that the same is free from any liens and encumbrances. If I am married, such authority is either exercised with the full consent of my spouse or in my own capacity as sole administrator and owner of the Plan, proof of which is hereby attached.

My signature indicates that I have reviewed and certified the correctness of all information stated in this form.

I hereby consent, without need of prior notification, to the processing, storage, and disclosure by the Company of all such personal and/or sensitive personal information in this form for the enforcement of my plan contract, and for all purposes deemed fit by the Company, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk management, underwriting and administration of insurance coverage and claims, data analytics and data sharing with the Company. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured. PhilPlans shall retain the information for the duration of your contract/business with it and for a reasonable time thereafter to comply with its legal obligations.

I understand that as the owner of my data, I may contact the Company at any time during normal business hours and exercise the following rights, among others: (a) to be informed of the type and extent of data in the Company's possession; (b) to have my data disposed of or deleted, subject to the legitimate need of the Company in order to fulfill its contractual obligations to me; (c) to correct or update my data as needed; and (d) to receive a copy of the data within a reasonable time upon request.

I agree that the company may store the said data for the duration of the contract and a reasonable time thereafter.

I understand that I may contact the Data Protection Officer of the Company for any concerns involving my data or privacy rights.

I hereby certify that I have fully read and understood the benefits and features of this plan and agree to be bound by the provisions of the plan contract.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_ at \_\_\_\_\_, Philippines.

## WITH MY MARITAL CONSENT (if married)

\_\_\_\_\_  
SPOUSE (Signature over Printed Name)

\_\_\_\_\_  
TRANSFEROR (Signature over printed name)

## CONFORME:

I, \_\_\_\_\_, the Transferee of the Plan, hereby certify that to the best of my knowledge, the foregoing information as to the personal circumstances of the Transferor from whom I derived my title to the Plan and all my personal information, declarations and representations as well as all information pertaining to my nominee and/or beneficiary/ies, if any, are true and correct.

I am aware that only the plan benefits less availments, if any, are transferred to me. It is agreed that PhilPlans shall pay only the plan benefits incurred on or after the date of approval of the transfer in my favor and the issuance of a new Plan Contract and Certificate of Full Payment in my name.

I am aware and agree that, notwithstanding any provisions in the Plan Contract, I am no longer able to further transfer, assign or otherwise dispose of the Plan to a third party..

My signature indicates that I have reviewed and certified the correctness of all information stated in this form.

I hereby consent, without need of prior notification, to the processing, storage, and disclosure by the Company of all such personal and/or sensitive personal information in this form for the enforcement of my plan contract, and for all purposes deemed fit by the Company, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk management, underwriting and administration of insurance coverage and claims, data analytics and data sharing with the Company. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured. PhilPlans shall retain the information for the duration of your contract/business with it and for a reasonable time thereafter to comply with its legal obligations.

I understand that as the owner of my data, I may contact the Company at any time during normal business hours and exercise the following rights, among others: (a) to be informed of the type and extent of data in the Company's possession; (b) to have my data disposed of or deleted, subject to the legitimate need of the Company in order to fulfill its contractual obligations to me; (c) to correct or update my data as needed; and (d) to receive a copy of the data within a reasonable time upon request.

I agree that the company may store the said data for the duration of the contract and a reasonable time thereafter.

I understand that I may contact the Data Protection Officer of the Company for any concerns involving my data or privacy rights.

I hereby certify that I have fully read and understood the benefits and features of this plan and agree to be bound by the provisions of the plan contract.

Dated this \_\_\_\_\_ day of \_\_\_\_\_ year \_\_\_\_\_ at \_\_\_\_\_, Philippines.

\_\_\_\_\_  
**TRANSFEEE**  
(Signature over Printed Name)

## SPECIMEN SIGNATURES OF THE TRANSFEEE

LONG FORM SIGNATURE		SHORT FORM SIGNATURE	
1.		1.	
2.		2.	

## SIGNED IN THE PRESENCE OF:

\_\_\_\_\_  
(Signature over printed name)

\_\_\_\_\_  
(Signature over printed name)

REPUBLIC OF THE PHILIPPINES )  
\_\_\_\_\_) S.S

Before me, the undersigned Notary Public for and in \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ personally appeared:

Name : \_\_\_\_\_ Valid ID \_\_\_\_\_ / Number \_\_\_\_\_ / Exp Date \_\_\_\_\_

Known to me and to me known to be the same persons who executed the foregoing Agreement, and acknowledged to me that they executed the same as their own free and voluntary act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my seal at \_\_\_\_\_, Philippines, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Doc. No. \_\_\_\_\_;  
Page No. \_\_\_\_\_;  
Book No. \_\_\_\_\_;  
Series of \_\_\_\_\_.

**NOTARY PUBLIC**