



14/F STI Holdings Center
6764, Ayala Avenue
1226 Makati City

**APPLICATION FOR AMENDMENT OF PLAN CONTRACT
FOR INDIVIDUAL AND SALARY ALLOTMENT**

PLAN NUMBER	PLANHOLDER'S NAME (Please print)	NATIONALITY
MOBILE NO.	EMAIL ADDRESS	TELEPHONE NO.
<input type="checkbox"/> Photocopy of 1 valid ID bearing photo and signature <input type="checkbox"/> Processing Fee (Processing fee is Non-Refundable)		
COMPLETE ADDRESS:		

REQUEST	PARTICULARS																						
<input type="checkbox"/> CHANGE NAME / DATE OF BIRTH <input type="checkbox"/> CHANGE <input type="checkbox"/> CORRECTION Note: ✓ If change of name is due to mere corrections, attach photocopy of birth certificate. Original must be presented. ✓ If change in name, attach photocopy of marriage contract or copy of other legal documents. Original must be presented.	CURRENT NAME ON RECORD: _____ NEW/CORRECT NAME: _____ (For Correction of Name) CORRECT DATE OF BIRTH : _____ (For correction of Birthday) (MONTH / DAY / YEAR) GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female Reason: <input type="checkbox"/> Married to _____ on (DATE) _____ <input type="checkbox"/> Others: _____																						
<input type="checkbox"/> CHANGE OF NATIONALITY	FROM: _____ TO: _____																						
<input type="checkbox"/> CHANGE MODE OF PAYMENT	<table border="1"> <thead> <tr> <th>CURRENT MODE OF PAYMENT</th> <th>NEW MODE OF PAYMENT</th> </tr> </thead> <tbody> <tr> <td>Mode of Payment: _____</td> <td>Mode of Payment: _____</td> </tr> <tr> <td>Installment Amount: _____</td> <td>Installment Amount: _____</td> </tr> </tbody> </table>	CURRENT MODE OF PAYMENT	NEW MODE OF PAYMENT	Mode of Payment: _____	Mode of Payment: _____	Installment Amount: _____	Installment Amount: _____																
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<input type="checkbox"/> CHANGE BENEFICIARY (<i>Change/Delete Existing Beneficiary</i>) <input type="checkbox"/> Change Primary Beneficiary/ies <input type="checkbox"/> Change Secondary Beneficiary/ies <input type="checkbox"/> Change both Primary and Secondary Beneficiary/ies <input type="checkbox"/> ADDITIONAL BENEFICIARY (<i>Retain existing and add New</i>) <input type="checkbox"/> Primary Beneficiary/ies <input type="checkbox"/> Secondary Beneficiary/ies <input type="checkbox"/> Primary and Secondary Beneficiary/ies Note: ¹ All listed Primary Beneficiaries shall get equal share of benefits unless otherwise specified. ² 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 the Company from any further liability under the plan contract.	<table border="1"> <thead> <tr> <th>BENEFICIARY</th> <th>NAME</th> <th>AGE</th> <th>RELATIONSHIP TO PLANHOLDER</th> </tr> </thead> <tbody> <tr> <td rowspan="2">¹PRIMARY</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td rowspan="2">SECONDARY</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>²GUARDIAN TO MINOR BENEFICIARY/IES</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	BENEFICIARY	NAME	AGE	RELATIONSHIP TO PLANHOLDER	¹ PRIMARY	_____	_____	_____	_____	_____	_____	SECONDARY	_____	_____	_____	_____	_____	_____	² GUARDIAN TO MINOR BENEFICIARY/IES	_____	_____	_____
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<input type="checkbox"/> CHANGE OF NOMINEE DESIGNATION (FOR EDUCATION PLAN ONLY) <i>Additional Requirement: Nominee's Birth Certificate</i>	NEW NOMINEE _____ DATE OF BIRTH (MM/DD/YYYY) _____ GRADE/YEAR _____ RELATIONSHIP TO PLANHOLDER _____																						
<input type="checkbox"/> REPLACEMENT OF LOST CONTRACT <input type="checkbox"/> REPLACEMENT CERTIFICATE OF FULL PAYMENT (CFP)	Requirement submitted: <input type="checkbox"/> Notarized Affidavit of Loss <input type="checkbox"/> Others (Pls specify) _____																						
<input type="checkbox"/> OTHERS (Please specify) : _____	Note: Other documents shall be required depending on the type of change request specified.																						

I hereby agree that this application for amendment of Plan Contract shall be effective only upon the approval of PhilPlans First, Inc. ("PhilPlans").

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.

WITNESS:	_____	1. _____
	SERVICING SALES COUNSELOR (SIGNATURE OVER PRINTED NAME)	SIGNATURE OVER PRINTED NAME OF PLANHOLDER
_____	SALES COUNSELOR'S CODE	2. _____
		SIGNATURE OVER PRINTED NAME OF PLANHOLDER

FOR HEAD OFFICE USE ONLY	PROCESSED BY: _____	DATE: _____
REMARKS:		