

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

PLAN NUMBER	PLANHOLDER'S NAME (Please print)	NATIONALITY	OR NUMBER: OR DATE: OR AMOUNT:
PHONE NUMBER (Please include AREA CODE) ()	MOBILE NUMBER	E-MAIL ADDRESS	<input type="checkbox"/> Photocopy of 2 valid IDs bearing photo and signature <input type="checkbox"/> Processing Fee (Processing fee is Non-Refundable)

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 (Change/Delete Existing Beneficiary) <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 (Retain existing and add New) <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) : _____	<i>Note: Other documents shall be required depending on the type of change request specified.</i>																						

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 manual or automated processing, storage and disclosure by PhilPlans, and its authorized employees and representatives, within or without the Philippines, in accordance with the Data Privacy Act and its implementing rules and regulations, of all such personal and/or sensitive personal information in this form, and all included attachments, solely for all purposes relevant to the enforcement and maintenance of my plan contract, and for all purposes deemed fit by PhilPlans, which shall include issuance, implementation and handling insurance policies, direct marketing, profiling, risk assessment, underwriting and administration of insurance coverage and claims, data analytics and data sharing with PhilPlans.

I also agree that my contact details may be utilized by PhilPlans to provide relevant updates of my plan, as well as company and product developments. Said consent also extends likewise from those persons whose information I have provided, whose consent I have secured.

Lastly, I agree that PhilPlans may store the same for the duration of the contract and a reasonable time thereafter.

Dated this _____ day of _____ year _____ at _____, Philippines.

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.

WITNESS:

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

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