

Policy Amendment Request Form



Individual Policyowner

REMINDERS:

Please use CAPITAL LETTERS and black ink.
 Tick the appropriate box to indicate your choice.
 Please do not sign on a blank form.
 If not applicable, put "N/A" in all empty fields.
 One form for multiple policies may be used for:

- Minor amendment requests; and
 - Major amendment requests if the Policyowner, Life Insured, and Irrevocable Beneficiary/ies are all the same.
- Otherwise, the individual submission of Policy Amendment Request Form for each policy will be required.

PRU LIFE INSURANCE CORPORATION OF U.K.
 9/F Uptown Place Tower 1, 1 East 11th Drive, Uptown Bonifacio,
 1634 Taguig City, Philippines
 Customer helpdesk: (632) 8683 9000, (632) 8884 8484, (632) 8887 LIFE
 within Metro Manila, 1 800 10 PRULINK for domestic toll-free
 Email: contact.us@prulifeuk.com.ph Website: www.prulifeuk.com.ph

POLICY NUMBERS

PAI 22-000000

DETAILS OF POLICYOWNER

SURNAME <input type="text"/>		DATE OF BIRTH (mm/dd/yyyy) <input type="text"/>	NATIONALITY <input type="text"/>
GIVEN NAME <input type="text"/>		MOBILE NUMBER <input type="text"/>	TELEPHONE NUMBER <input type="text"/>
MIDDLE NAME <input type="text"/>		OCCUPATION (State exact duties; if member of AFP/PNP, state rank) <input type="text"/>	
OTHER LEGAL NAME/ALIAS <input type="text"/>		NAME OF EMPLOYER/NAME OF BUSINESS <input type="text"/>	

Do you currently file a tax return in the United States of America? Yes No

With changes in personal details of the Policyowner in the records of Pru Life UK? Yes (Fill out the additional KYC details section) No

DETAILS OF AMENDMENT REQUEST

MINOR AMENDMENT

1 ADDITIONAL KNOW-YOUR-CUSTOMER (KYC) DETAILS OF THE POLICYOWNER

If there are no changes in the following information, you may skip this section. Any information provided in this section will be used to update your personal details in our records.

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	SALUTATION (e.g. Mr., Mrs., Miss, etc.) <input type="text"/>	AGE <input type="text"/>	PLACE OF BIRTH (city/province, country) <input type="text"/>
CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Others <input type="text"/>	TIN <input type="text"/>	SSS/GSIS <input type="text"/>	
MOBILE NUMBER <input type="text"/>	TELEPHONE NUMBER <input type="text"/>	EMAIL ADDRESS <input type="text"/>	
EMPLOYER/BUSINESS TELEPHONE NUMBER <input type="text"/>	EMPLOYER/BUSINESS ADDRESS (number, street, municipality/city, province) <input type="text"/>		
EMPLOYER/BUSINESS MOBILE NUMBER <input type="text"/>	COUNTRY <input type="text"/>	ZIP CODE <input type="text"/>	
EMPLOYER/BUSINESS EMAIL ADDRESS <input type="text"/>	SOURCES OF FUNDS <input type="checkbox"/> Salary <input type="checkbox"/> Business <input type="checkbox"/> Others <input type="text"/>		
GROSS ANNUAL INCOME (in PhP) <input type="text"/>	NET WORTH (in PhP) <input type="text"/>		
PRESENT ADDRESS (number, street, municipality/city, province) <input type="text"/>	PERMANENT ADDRESS (number, street, municipality/city, province) <input type="text"/>	<input type="checkbox"/> Tick if same as present address	
COUNTRY <input type="text"/>	ZIP CODE <input type="text"/>	COUNTRY <input type="text"/>	ZIP CODE <input type="text"/>
Preferred billing address of Policyowner for Pru Life UK correspondence: <input type="checkbox"/> Present Address <input type="checkbox"/> Permanent Address <input type="checkbox"/> Employer/Business Address			
REASON FOR CHANGE IN ADDRESS (Note: If the new address is the same as the servicing agent's address, please indicate the relationship with the agent and reason for such request. This request is subject to further evaluation and approval in compliance with Pru Life UK guidelines.) <input type="text"/>			

FOR OFFICIAL USE ONLY

BRANCH RECEIPT DETAILS	HEAD OFFICE RECEIPT DETAILS
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DETAILS OF AMENDMENT REQUEST

2 CHANGE DETAILS OF LIFE INSURED

Please fill out only the fields that need to be updated/changed.

SURNAME <input style="width: 100%;" type="text"/>			MOBILE NUMBER <input style="width: 100%;" type="text"/>		TELEPHONE NUMBER <input style="width: 100%;" type="text"/>	
GIVEN NAME <input style="width: 100%;" type="text"/>			EMAIL ADDRESS <input style="width: 100%;" type="text"/>			
MIDDLE NAME <input style="width: 100%;" type="text"/>			TIN <input style="width: 100%;" type="text"/>		SSS/GSIS <input style="width: 100%;" type="text"/>	
OTHER LEGAL NAME/ALIAS <input style="width: 100%;" type="text"/>			OCCUPATION (State exact duties; if member of AFP/PNP, state rank) <input style="width: 100%;" type="text"/>			
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		CIVIL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Others <input style="width: 50%;" type="text"/>		SALUTATION (e.g. Mr., Mrs., Miss, etc.) <input style="width: 100%;" type="text"/>		
DATE OF BIRTH (mm/dd/yyyy) <input style="width: 50%;" type="text"/>		AGE <input style="width: 50%;" type="text"/>		NATIONALITY <input style="width: 100%;" type="text"/>		
PLACE OF BIRTH (city/province, country) <input style="width: 100%;" type="text"/>						
PRESENT ADDRESS (number, street, municipality/city, province) <input style="width: 100%; height: 40px;" type="text"/>						
COUNTRY <input style="width: 100%;" type="text"/>			ZIP CODE <input style="width: 100%;" type="text"/>			
PERMANENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as present address						
<input style="width: 100%; height: 40px;" type="text"/>						
COUNTRY <input style="width: 100%;" type="text"/>			ZIP CODE <input style="width: 100%;" type="text"/>			
EMLOYER <input style="width: 100%; height: 40px;" type="text"/>			NATURE OF BUSINESS OF EMPLOYER <input style="width: 100%;" type="text"/>			
EMPLOYER'S MOBILE NUMBER <input style="width: 100%;" type="text"/>		EMPLOYER'S TELEPHONE NUMBER <input style="width: 100%;" type="text"/>				
EMPLOYER'S EMAIL ADDRESS <input style="width: 100%;" type="text"/>						
EMPLOYER/BUSINESS ADDRESS (number, street, municipality/city, province) <input style="width: 100%; height: 40px;" type="text"/>						
COUNTRY <input style="width: 100%;" type="text"/>			ZIP CODE <input style="width: 100%;" type="text"/>			

3 CHANGE IN BENEFICIARIES

Accomplish this section only if there are changes in the Beneficiary Details.

Pru Life UK will assume the following default options unless stated otherwise:

a) Beneficiary Designation – Revocable

b) % Share – equal sharing among Beneficiaries

TYPE OF REQUEST <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input style="width: 100%;" type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input style="width: 100%;" type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		
	RELATIONSHIP TO INSURED <input style="width: 100%;" type="text"/>		% SHARE <input style="width: 50%;" type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary		BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable		PLACE OF BIRTH <input style="width: 100%;" type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner						COUNTRY <input style="width: 100%;" type="text"/>		ZIP CODE <input style="width: 100%;" type="text"/>
TYPE OF REQUEST <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input style="width: 100%;" type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input style="width: 100%;" type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		
	RELATIONSHIP TO INSURED <input style="width: 100%;" type="text"/>		% SHARE <input style="width: 50%;" type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary		BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable		PLACE OF BIRTH <input style="width: 100%;" type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner						COUNTRY <input style="width: 100%;" type="text"/>		ZIP CODE <input style="width: 100%;" type="text"/>
TYPE OF REQUEST <input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Change in details	SURNAME, GIVEN NAME, MIDDLE NAME <input style="width: 100%;" type="text"/>				DATE OF BIRTH (mm/dd/yyyy) <input style="width: 100%;" type="text"/>		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		
	RELATIONSHIP TO INSURED <input style="width: 100%;" type="text"/>		% SHARE <input style="width: 50%;" type="text"/>	TYPE OF BENEFICIARY <input type="checkbox"/> Primary <input type="checkbox"/> Secondary		BENEFICIARY DESIGNATION <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable		PLACE OF BIRTH <input style="width: 100%;" type="text"/>	
	PRESENT ADDRESS (number, street, municipality/city, province) <input type="checkbox"/> Tick if same as Policyowner						COUNTRY <input style="width: 100%;" type="text"/>		ZIP CODE <input style="width: 100%;" type="text"/>

Please use the special instructions box below if there are more than three (3) Primary and/or Secondary Beneficiaries.

SPECIAL INSTRUCTIONS <input style="width: 100%; height: 60px;" type="text"/>

DETAILS OF AMENDMENT REQUEST

4 CHANGE METHOD OF PAYMENT

Cash Post-dated check

5 RESUME CREDIT CARD/AUTO-DEBIT ARRANGEMENT (ADA) BILLING

I opt to resume my credit card/ADA billing and allow Pru Life UK to collect all unpaid premiums from my most recent enrolled/existing card.

6 STOP CREDIT CARD/AUTO-DEBIT ARRANGEMENT (ADA) BILLING

I opt to stop my credit card/ADA billing and agree to the following conditions:
Request must be received by Pru Life UK at least five (5) working days before the premium due date. All unpaid premiums shall be collected upon resumption of the billing.
To prevent lapsation of the Policy/ies, you may select from Pru Life UK's payment facilities.

7 CHANGE MODE OF PAYMENT

Annual Semi-annual Quarterly Monthly

8 PREMIUM HOLIDAY AVAILMENT

I opt to avail of the Premium Holiday. Premium payments may be discontinued at any time, as long as the fund value is sufficient to cover the applicable charges on the Policy/ies. Once the fund value is insufficient to cover the said outstanding charges, the Policy/ies will be terminated.
If this feature is availed of, corresponding charges will be applied (applicable for Elite plans).

9 NON-FORFEITURE OPTION (FOR TRADITIONAL PLANS ONLY)

Cash surrender value Reduced paid-up insurance Automatic premium loan option Extended term insurance

10 DIVIDEND OPTION AND SUB-OPTION (FOR TRADITIONAL PLANS ONLY)

Paid in cash Used to pay a portion of premium Used to buy paid-up insurance Left to accumulate and earn interest sub-option:
 Ordinary accumulation
 Self-liquidation
 Fully paid-up
 Early maturity
 Cash allowance

11 DIVIDEND CONSENT (FOR TRADITIONAL PLANS ONLY)

I agree to use any dividend accumulation of the Policy/ies towards any premium default option in effect.

MAJOR AMENDMENT

12 PREMIUM

Increase Decrease Amount:

13 SUM ASSURED

Increase Decrease Amount:

14 RIDERS

TYPE OF REQUEST	NAME OF RIDER	RIDER COVERAGE
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		
<input type="checkbox"/> Add <input type="checkbox"/> Delete <input type="checkbox"/> Increase coverage <input type="checkbox"/> Decrease coverage		

Please use the special instructions box below if there are more than ten (10) riders.

SPECIAL INSTRUCTIONS

DETAILS OF AMENDMENT

15 RECONSIDERATION OF RATING

Health

- Submission of medical documents is required.
- The Policyowner will shoulder the expenses for medical examinations.
- Request is subject to the approval of Pru Life UK.

Occupation

- Completely fill out the "Change in Occupation" details.
- A Certificate of Employment from the Life Insured's new employer is required.

CHANGE OF OCCUPATION DETAILS

NEW OCCUPATION

NATURE OF WORK OR NATURE OF BUSINESS (if self-employed)

EMPLOYER

NATURE OF BUSINESS OF EMPLOYER

EMPLOYER/BUSINESS ADDRESS (number, street, municipality/city, province)

COUNTRY

ZIP CODE

JOB DESCRIPTION

SPECIAL INSTRUCTIONS

STATEMENT OF INSURABILITY

This section should be completed and signed by the Life Insured for any increase in insurance coverage, inclusion of riders, or any request involving additional risks. The Policyowner portion should be completed if the Policy/ies has/have existing payor waiver/payor term rider.

	Life Insured	Policyowner	Details
1. Are you in good health, free from all diseases, deformities and abnormalities? If no, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Since the issuance of the Policy/ies or the last reinstatement, have you:			Details of "YES" answer
a) Ever had any illness or recurrent illness, injury, medication, or disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b) Ever had any medical consultation, hospitalization, or surgical operation due to any condition, or been prescribed for or attended by a physician or practitioner for any cause, or undergone any diagnostic test/s? Please indicate results.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c) Ever been confined or hospitalized in a clinic, institution, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
d) Ever changed your customary occupation, or country of residence? If yes, please indicate details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
e) Ever had any application for life, accident or health insurance, or reinstatement that was declined, postponed, rated, or modified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
f) Experienced death among the immediate members of your family? If yes, please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. For female clients, are you now pregnant? If yes, how many months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

AUTHORIZATION TO FURNISH MEDICAL INFORMATION

In order to be able to process this request, the Policyowner and/or Life Insured authorize PRU LIFE INSURANCE CORPORATION OF U.K. and its authorized representatives, including its investigators, to obtain the relevant medical information from hospitals, medical facilities, and physicians. A photocopy of this authorization shall be deemed as valid as the original.

DECLARATION OF UNDERSTANDING

PLEASE READ CAREFULLY BEFORE SIGNING THE POLICY AMENDMENT REQUEST FORM:

By signing this Policy Amendment Request Form ("Form"), I (i.e. each of the Policyowner, the Life Insured, and the Irrevocable Beneficiary/ies, if any) declare, agree to, and authorize the following:

- All the statements and answers in this Form and any information given to Pru Life UK or its medical examiners, including any amendments, are complete, true, correct and binding on all parties in interest under the Policy/ies.
- Pru Life UK reserves the right to request for additional medical evidence to assess my health. Any physician, hospital, clinic or medical organization is authorized to furnish Pru Life UK with any medical information pertaining to me.
- Prior to the approval of the amendment of the Policy/ies applied for, I agree to inform Pru Life UK of any change in my (a) state of health, and (b) occupation or activities.
- I will update Pru Life UK in a timely manner of any change in details previously provided especially with respect to a change in citizenship, tax status or tax residency. If the Policyowner is a corporation, changes in registered address, address of place of business, substantial shareholders, legal or beneficial owners who own or control more than 20% of the Policyowner will also be disclosed. If any of these changes occurs or if any other information comes to light concerning such changes, I agree to provide additional documents or information as may be requested by Pru Life UK, including but not limited to duly completed and/or executed (and, if necessary, notarized) tax declarations or forms.
- This application is subject to the guidelines on anti-money laundering and financial underwriting. Pru Life UK can disapprove this application or terminate the Policy/ies if I fail to provide the necessary information relating to this application or relevant transaction or if this application violates the said guidelines.

DECLARATION OF UNDERSTANDING

- 6. I fully understand and accept the consequences of the amendment requested hereunder.
- 7. I agree to receive financial and other policy related information through the mobile number and email address provided to Pru Life UK. Pru Life UK shall not be liable for claims or liabilities incurred as a result of the dissemination of personal information through said facilities.
- 8. I understand that Irrevocable Beneficiary/ies is/are given equal rights over the Policy/ies as the Policyowner. I, as the Policyowner, cannot exercise any of my rights under the Policy/ies without the consent and signature of all Irrevocable Beneficiary/ies. Such rights include but are not limited to decrease or deletion of any benefit or the change, addition or deletion of beneficiaries.
- 9. I understand that I must submit this form within three (3) months from the date of signing.

Purpose Statement:

We will process the information you have provided in this form for the purpose of handling your request in accordance with applicable privacy laws and regulations. During processing, we may share the information you provided to our authorized data processors, including couriers and contractors for anti-money laundering systems, photocopying, scanning, indexing and printing services. We may share your information with governmental and other regulatory authorities, or self-regulatory bodies in various jurisdictions as required or allowed by applicable laws and regulations. Any information collected may be retained by Pru Life UK and our authorized data processors until ten (10) years from the date of termination of the policy.

You may revisit our privacy policy through our website at (<https://www.prulifeuk.com.ph/en/footer/privacy-policy/>). For data privacy concerns, please contact our Data Privacy Officer at:

Telephone:	(632) 8887 5433 for Metro Manila, 1 800 10 7785465 via PLDT landline for domestic toll-free
Email:	dpo@prulifeuk.com.ph

EXECUTED AT THIS (mm/dd/yyyy)
PLACE

- ✓ Signature over printed name of POLICYOWNER
- ✓ Signature over printed name of LIFE INSURED
- ✓ Signature over printed name of IRREVOCABLE BENEFICIARY/IES/ASSIGNEE

- ✓ Signature over printed name of WITNESS
- ✓ Signature over printed name of IRREVOCABLE BENEFICIARY/IES/ASSIGNEE
- ✓ Signature over printed name of IRREVOCABLE BENEFICIARY/IES/ASSIGNEE

CERTIFICATION OF CUSTOMARY SIGNATURE FOR POLICYOWNER

This is to certify that I am the same person who signed the Application for Life Insurance. I confirm that the declarations and information therein were given by me personally and that they are true and complete to the best of my knowledge.

Finally, I certify that the signature appearing on all my forms and valid IDs is my customary signature, as follows:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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CERTIFICATION OF CUSTOMARY SIGNATURE FOR IRREVOCABLE BENEFICIARY/IES

Full name of Irrevocable Beneficiary 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Full name of Irrevocable Beneficiary 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Full name of Irrevocable Beneficiary 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>