Beneficial LIFE INSURANCE COMPANY, INC.

166 Salcedo St., Legaspi Village, Makati City 1229 P.O. Box 1903
T (+632) 8818-8671 • F (+632) 8554-7539 to 30, (+632) 8554-7527

Policyholder	GCL-1016
Group Policy Number	
Amount of Loan Approved	
Term of Loan	
Date of Release	
Maturity Date	
Premium Due	

Individual Application for Group Loan Redemption Insurance Coverage

1 General Information

Name of Borrower (Last, First, M.I.) ☐ Male ☐ Female

Residence Address (no., street, municipality)

Province	Nationality	Age	TIN

Date of Birth	Tel. No.	Occupation/Specific Job	Source of Income

Employer's Name & Address

2 Beneficiary

Name	Relationship to PI	Birthday	Age

Trustee if any beneficiary is under 18 years of age:	Relationship of Trustee to Minor Beneficiary:

In the event of a claim, Beneficial Life Insurance Company, Inc. shall pay to the Policyholder the proceeds under the Policy which shall not exceed the loan balance at the time of the death of the Insured Debtor. The excess from the proceeds, if any, shall be paid to the designated beneficiary/ies, and in the absence of the latter, shall be paid in accordance with the group policy contract.

3 Declaration and Representations

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

1. Within the last two (2) years, I have not made any application for insurance which has been declined, postponed, withdrawn or accepted on a basis other than applied for, EXCEPT _____
2. I have not had any symptoms or sought advice for, or have been treated for high blood pressure, stroke, heart trouble diabetes cancer or tumour, chest pain, bleeding from the bowel, or blood in your sputum, or has treatment for any of these conditions been recommended by a physician or other practitioner, EXCEPT _____
3. Within the last five (5) years, I have not been admitted or been advised to be admitted as an in-patient to a hospital or clinic, EXCEPT for _____
4. I don't have any health symptoms or complains for which a physician has been consulted or treatment has been received, i.e. persistent fever, unexplained weight loss, loss of appetite, pain or swelling, etc., EXCEPT _____
5. Please enumerate any disease or consultation being done if any. _____
6. Are you pregnant? If so, how many months? (female applicant only) _____
7. Have you ever;
   a. Traveled to areas with reporting cases of COVID 19 within the past 30 days? ☐ Yes ☐ No
   b. Had any close contact of persons diagnosed with COVID 19 or have been placed under quarantine? (Close contact means having cared for, having lived with, or having had direct contacts with respiratory secretions and body fluids of person with COVID 19. ☐ Yes ☐ No
   c. Been diagnosed or treated for COVID 19? ☐ Yes ☐ No

(If any answers are "Yes" or any answers is in doubt, Please give date and details overleaf.)

4 Signatures

By signing this form and continuing to avail of BenLife's products and services, I hereby:

a) Certify that the above statements are true and complete and that all exceptions have been stated. I have not withheld any relevant information which might have otherwise affected the acceptance of my proposal. I understand and agree that the insurance applied for will become effective only upon acceptance by BenLife and the initial premium being fully paid by me. Any material falsity or misrepresentation in the foregoing, upon discovery thereof within one (1) year from the effectivity date of the insurance policy shall entitle BenLife to declare such policy null and void from the beginning.

b) Authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any of my health record, to give BenLife or its legal representaive, any and such all information; and agree that a photocopy of this Authorization shall be effective and valid as original.

c) Agree that these information (personal and sensitive) can be processed, shared, disclosed, transferred or used by BenLife including its shareholders, directors and employees, its affiliates and subsidiaries, advisors, representatives, external auditors, and its third party service providers within the rules set by the Data Privacy Act of 2012, as may be amended from time to time to, and relevant regulations, to commuinicate with me on BenLife's products and services; conduct data analytics, profiling and automate data processing; comply with regulatory requirements, legal and contractual obligations of BenLife; and for other reasonable purposes related to the services provided or improvement/upgrade in systems and business processes.

DISCLOSURE:

In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the following link: www.insurance.gov.ph.

Printed Name	Date Signed
Your Signature	Name of Witness
Place of Signing	Witness Signature

For Benlife Use Only

Remarks: _____

Class Rating: _____

Sub-standard Rating: _____

Others: _____

BORROWER

HEIGHT :

WEIGHT :