Policy Change Form

Policy Number | | | | | | | | | FWP/FSC Code | | | | | | | | |

Please fill in block letters and tick appropriate boxes and circles. Requests received by FWD service counters within the cut-off time of 2:00 PM will be processed within the day. Requests received beyond cut-off time will be processed the next business day.

1. Personal Data of Policy Owner (Your personal information in our database shall be updated based on the details you provide below.)

Name of Policy Owner

Title	First Name	Middle Name	Last Name	Ext Name

Date of Birth (mm/dd/yyyy)	Place of Birth	Country of Birth	Nationality

2. Change Request (please check the box and indicate the change intended)

A. ☐ CHANGE / CORRECTION OF NAME: ◯ Policy Owner ◯ Insured ◯ Beneficiary

Title	First Name	Middle Name	Last Name	Ext Name

Reason for Change: ◯ Marriage ◯ Legal Separation ◯ Others: ____________________

Note: Please submit supporting document/s such as a Birth Certificate or valid Government-issued ID.

B. ☐ CHANGE OF NATIONALITY: From: ____________________ To: ____________________

C. ☐ CORRECTION IN DATE OF BIRTH OF: ◯ Policy Owner ◯ Insured

Change Date of Birth To: m m / d d / y y y y

Note: 1) Premiums may be adjusted if correction in date of birth results to a change in age. 2) Please submit supporting document/s such as a Birth Certificate or valid Government-issued ID.

D. ☐ CHANGE CONTACT INFORMATION: (Country Code) (Area Code) (Telephone/Mobile Number)

◯ Residence Telephone Number		ex: (63)(43)765-4321
◯ Business/Office Telephone Number		ex: (63)(43)765-4321
◯ Mobile Phone Number		ex: (63)(43)765-4321

E. ☐ CHANGE PREFERRED MAILING ADDRESS: ◯ Email ◯ Residence ◯ Business/Office

No. and Street	Barangay/Subdivision	
Municipality,Town/City	Province/Country	Zip Code

Email Address:	*Note: Hardcopy of notices will only be sent if preferred mailing address is Residence or Business/Office.*

F. ☐ CHANGE PAYMENT MODE TO: ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly (ADA/ACA only)* **Fill-out section "H"*

G. ☐ CHANGE BILLING METHOD TO: ◯ CASH ◯ ADA* ◯ ACA* **Fill-out section "H"*

H. ☐ CHANGE BANK DETAILS:

◯ ADA *(Note: Please submit newly accomplished and signed ADA form with complete bank details)*

◯ ACA *(Note: Please provide bank details below and submit copy of the front view of the newly elected Credit Card)*

Name of Credit Card Owner as it appears on Card: ____________________

Credit Card Number | | | | | | | | | | | | | | | | | Expiry Date m m / y y y y

Card Type: ◯ Visa ◯ MasterCard ◯ JCB ◯ AmEx   Bank Name ____________________

I. ☐ CHANGE DIVIDEND OPTION TO: ◯ Leave to Earn Interest ◯ Pay in Cash ◯ Use to Reduce Premium ◯ Use to Purchase Additional Insurance

J. ☐ CHANGE NON-FORFEITURE OPTION TO: ◯ Extended Term Insurance (ETI) ◯ Premium Loan with Interest (PL) ◯ Reduce Paid Up Insurance (RPU) ◯ Surrender for Cash Value (SCV)

K. ☐ CHANGE OF COVERAGE:

Note: For any change in coverage, please submit new Sales Illustration Form. Increase in coverage is subject for submission of a Health Statement Form.

◯ Decrease Coverage to: ____________________ ◯ Increase Coverage to: ____________________

◯ Sum Assured

◯ Rider *(Pls. inidicate name of Rider below)*

____________________ ____________________

____________________ ____________________

____________________ ____________________

L. ☐ CHANGE OF RIDER: *Note: For any change of riders, please submit a new Sales Illustration Form. Additional rider/s is subject to company approval and is processed upon submission of a Health Statement Form.*

	Name of Rider	Rider Coverage
◯ Delete Rider		
◯ Add Rider		

Policy number: ____________________________

M. ☐ CHANGE OF PLAN: To: ______________________________

Note: Change of Plan is subject to Company approval and is processed upon submission of a Health Statement Form.

N. ☐ CHANGE BENEFICIARY/IES

Please indicate the complete list of your intended beneficiaries. Upon written confirmation by FWD, this will supersede any previous designations including those written in your insurance application form or any prior Policy Change Form accepted by the Company.

IRR	REV	PRIM	CON	Name (Last, First, Ext, MI)	Date of Birth (mm/dd/yyyy)	Relationship	Place of Birth	Nationality	Share
○	○	○	○						___ %
○	○	○	○						___ %
○	○	○	○						___ %
○	○	○	○						___ %

Note: Please use extra sheet if space provided is not enough

O. ☐ UPDATE SIGNATURE: *Note: Please submit copy of valid ID bearing updated signature.*

____________________	____________________	____________________
Previous Signature	Current Signature	Current Signature

P. ☐ EXTENSION OF GRACE PERIOD:

I request for a 31-day extension of the Grace Period on my quarter/semi-annual/annual premium due.

Due Date : m m / d d / y y y y

Premium due: ____________________

This extension is a special privilege offered to the Policy Owner once every policy year. The next extension may be requested not earlier than: m m / d d / y y y y

P. ☐ OTHER SERVICE REQUEST:

3. U.S. Tax Declarations

1. Are you a citizen, taxpayer, passport holder or green card holder of the U.S. or were born in the U.S.? ○ Yes ○ No
   If yes, please provide a copy of your IRS W-Form and the below information:
   U.S. I.D. / Passport no. / Green Card No. ____________________
   U.S. Tax Identification Number / Social Security Number ____________________
   U.S. Permanent residence address ____________________

2. For Corporate Accounts only:
   Do you have a beneficial ownership holding 10% or more or any (direct or indirect) interest by a U.S. citizen, taxpayer, resident or entity? ○ Yes ○ No

4. Data Protection

FWD has appointed a Data Protection Officer to handle any inquiries relating to your personal information. If you would like to obtain a copy of the FWD Life Insurance Corporation Personal Data Policy and Practices, please write to the Corporate Data Protection Officer at 19/F, W Fifth Avenue Bldg., 5th Avenue cor. 32nd Street, Bonifacio Global City, Taguig City 1634, Philippines.

5. Declaration

I UNDERSTAND AND CONFIRM THAT:

1. The information I have provided above and in any supporting documents and/or records (collectively defined as this 'Form') are true and complete and shall form part and be the basis of the assessment of this request and approval. I understand that providing false, inaccurate or incomplete information may result in my transaction request being denied and shall give FWD the right to cancel the Policy, repudiate the claim or forfeit all payments to be made.
2. I understand that my request (if applicable) for policy change, reinstatement, or addition of coverage/rider which requires evidence of insurability shall not take effect unless duly approved by FWD and any required payment for the transaction request is paid in full. I further understand that the Incontestability and Suicide Exclusion provisions in the Policy shall apply and the period stated thereunder shall run upon FWD's approval of the request for reinstatement, increase or decrease of sum insured or rider.
3. I have fully disclosed all of my citizenships, tax status, residencies, relevant taxpayer identification numbers and agree to notify FWD within thirty (30) days of any changes to the above information. For the purposes of ensuring continued compliance, FWD may request information and/or documents from me including completed, executed and, if necessary, notarized tax declarations or forms.
4. I authorize FWD to disclose my personal and financial information to any government or tax authority (within or outside the Philippines) for the purposes of ensuring FWD's continual compliance with applicable laws, regulations, guidelines and good market practices. I also agree that FWD has the right to require any of my beneficiaries, claimants, assignees and/or payees to:
   a. provide FWD with their respective personal and financial information;
   b. sign and submit such documents as FWD may reasonably require; and
   c. authorize FWD to disclose such personal and financial information to relevant Filipino and/or foreign government and/or tax authorities.
5. The amounts invested in my policies have been declared to the relevant government and tax authorities (within or outside the Philippines) and none were derived, directly or indirectly, from illegal or unlawful activities and sources or from tax evasion. I authorize FWD to withhold payment of any amounts due to myself, my beneficiaries, claimants, assignees and/or payees if required by any relevant government or tax authorities (within or outside the Philippines).

Place of signing ____________________ Date: m m / d d / y y y y

____________________	____________________	____________________	____________________
Policy Owner's Signature over Printed Name	Irrevocable Beneficiary	Assignee *(if policy is assigned)*	FWP/FSC/Witness

Note: (1) If there is more than one irrevocable beneficiary or assignee, indicate signatures at the back of the form. (2) This section must be signed by the Policy Owner, the assignee, and all irrevocable beneficiaries, if any. If any of the irrevocable beneficiary/ies is below 18 years of age or predeceased, additional documents will be required. (3) If this form will be signed outside the Philippines, please have the form authenticated by the nearest Philippine Embassy or Consulate in your locality. (4) The witness should be a disinterested adult person.

Please do not sign on a blank form.