

**THE PHILIPPINE AMERICAN LIFE AND GENERAL INSURANCE COMPANY**

Philamlife Bldg., United Nations Avenue, Manila  
Telephone No. 528-2000 Fax No. 528-2001

**REQUEST FOR POLICY CHANGE**

INSURED'S NAME (PLEASE PRINT)
MAILING ADDRESS

Policy No. \_\_\_\_\_ Agent's Name \_\_\_\_\_  
 Document Enclosed  Health Statement Agent's Code \_\_\_\_\_  
 Policy Contract Payment: P \_\_\_\_\_  
 Others \_\_\_\_\_ CR# \_\_\_\_\_ Date \_\_\_\_\_

REQUEST	PARTICULARS																												
<input type="checkbox"/> Change name/date of birth <input type="checkbox"/> Insured <input type="checkbox"/> Owner (Attach birth certificate, marriage contract or other legal documents)	New Name _____ Former Name _____ Reason <input type="checkbox"/> Marriage to _____ on _____ <input type="checkbox"/> Correction <input type="checkbox"/> Legal Separation <input type="checkbox"/> Others _____																												
	Date of Birth _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female																												
<input type="checkbox"/> Change Mode of Payment	<input type="checkbox"/> Annual <input type="checkbox"/> Semi-annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly-SMPDC <input type="checkbox"/> Monthly - SA No. _____ (Enclose Authorization Form) Effective _____																												
<input type="checkbox"/> Change beneficiary designation  <input type="checkbox"/> Inclusion  <input type="checkbox"/> Deletion  Note: 1. If more than one beneficiary is named in any class, equal shares shall be assumed unless otherwise specified 2. If beneficiary designation is irrevocable, the written consent of the beneficiary is required. 3. If irrevocable beneficiary is a minor, legal guardianship is required.	<table border="1"> <thead> <tr> <th>Beneficiary</th> <th>Name</th> <th>Age</th> <th>Relationship</th> </tr> </thead> <tbody> <tr> <td>Primary</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Revocable</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Irrevocable</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Contingent</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Revocable</td> <td></td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Irrevocable</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Beneficiary	Name	Age	Relationship	Primary				<input type="checkbox"/> Revocable				<input type="checkbox"/> Irrevocable				Contingent				<input type="checkbox"/> Revocable				<input type="checkbox"/> Irrevocable			
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Trustee of minors _____ (Attach duly accomplished Trust Deed Agreement Form) Any payment made to the above named trustee of any amount payable to the beneficiary while such beneficiary is still below age 18 shall discharge the Company from any further liability under the policy.																													
<input type="checkbox"/> Non-Forfeiture Option	<input type="checkbox"/> Reduce Paid-Up Insurance <input type="checkbox"/> Extended Term Insurance Effective _____																												
<input type="checkbox"/> Change Dividend Option	<input type="checkbox"/> Option 1 - Pay in Cash <input type="checkbox"/> Option 3 - Accumulate with Interest <input type="checkbox"/> Option 2 - Reduce Premium <input type="checkbox"/> Option 4 - Purchase Paid Up Additions																												
<input type="checkbox"/> Change Plan/Riders/Face Amount (Attach Policy Contract & Health Statement except for reduction of amount and deletion of riders)	<input type="checkbox"/> Plan _____ <input type="checkbox"/> Face Amount _____ <input type="checkbox"/> Addition of Riders _____ <input type="checkbox"/> Deletion of Riders _____																												
<input type="checkbox"/> Change Effective Date (Allowed only once)	<input type="checkbox"/> Reinstatement by Redating <input type="checkbox"/> Redate to _____																												
<input type="checkbox"/> Remove/Reduce Rating (Attach Policy Contract & Health Statement)	<input type="checkbox"/> Medical Rating <input type="checkbox"/> Occupational Rating New Occupation _____ since (date) _____ <input type="checkbox"/> Employer's Name & Address _____																												
<input type="checkbox"/> Term Conversion	<input type="checkbox"/> Attained Age <input type="checkbox"/> Amount Converted _____ <input type="checkbox"/> Original Issue Age <input type="checkbox"/> New Plan _____ <input type="checkbox"/> Converting Agent _____																												
<input type="checkbox"/> Others (please specify)																													

I/ We, hereby, agree that should request be approved by the Company, such request shall, from the date of such approval, amend in accordance with the terms thereof so approved the contract contained in the policy to which the request refers.

Signed on \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_.

\_\_\_\_\_  
Witness/Agent

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Signature of Owner/Assignee/Irrevocable Beneficiary

**FOR OFFICE USE ONLY**

**REMARKS**

APPROVED BY \_\_\_\_\_ Registrar \_\_\_\_\_ Date \_\_\_\_\_

OFFICE

**HOME OFFICE ENDORSEMENT**