DREAM COLLEGE PLAN ENROLLMENT FORM:

Please send me my DREAM COLLEGE PLAN POLICY if I qualify. I understand that this does not obligate me in any way and that I will have an opportunity to inspect my policy for up to 10 days before I accept it. I understand that the insurance will take effect when my policy is issued and I have paid my first premium during my lifetime.

10-DAY FREE-LOOK GUARANTEE

(PLEASE PRINT)

FULL NAME OF PAYOR

(Mr. Mrs. Ms.) _____

First Middle Last

ADDRESS _____

_____

_____ ZIP CODE _____ TEL. NO/FAX _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

Month/Day/Year

AGE _____ ■ MALE ☐ FEMALE

OCCUPATION/PROFESSION _____SPECIFIC DUTIES _____

BUSINESS ADDRESS _____

_____ ZIP CODE _____ TEL. NO/FAX _____

TIN_____GSIS/SSS_____

SOURCE OF FUNDS_____

FULL NAME OF SCHOLAR

_____

First Middle Last

DATE OF BIRTH _____ PLACE OF BIRTH _____

AGE _____ ☐ MALE ■ FEMALE HEIGHT _____ WEIGHT _____

RELATIONSHIP TO PAYOR _____

FULL NAME OF BENEFICIARY _____

(For Life Benefits of Scholar) *Revocable* *Irrevocable*

RELATIONSHIP TOSCHOLAR _____ AGE _____

Please check the Plan you require:

☐ PLAN 100 ■ PLAN 300 ☐ PLAN 500 ☐ PLAN 1000

If premium is unpaid on expiry of Grace period, apply cash value, if any, to effect:

■ Premium Loan (PL) ☐ Paid-up Insurance (PUI)

☐ Cash Surrender Option

The moment there is default in payment until the end of the grace period provided in the Policy and no option has been elected, the PUI Option shall automatically take effect.

PLEASE CHECK "YES" OR "NO" TO EACH QUESTION

	PAYOR		SCHOLAR	
	Yes	No	Yes	No
Have you or the Scholar consulted any doctor for medical treatment, or advice for treatment, or confined in a hospital, clinic or similar institution during the past five years?	☐	☐	☐	☐
Have you or the Scholar ever been advised that you had: heart trouble, high blood pressure, cancer, diabetes, epilepsy or tuberculosis? (If 'YES', please circle which ailments)	☐	☐	☐	☐
Are you or the scholar aware of any impairement in your health, or physical condition?	☐	☐	☐	☐

If you answered "YES" to any of the above questions, please give full details: (Use another sheet if necessary)

Person treated _____

Physician's Name _____

Address/Name of Hospital _____

Date and Nature of Consultation/Sickness/Impairment _____

Declaration on Existing Policy(ies)

Total Life Insurance inforce on:

Ins. Co. Basic/Cover Accident Rider/ Year of Issue

_____

Proposed Insured: _____

Applicant/Owner: _____

(If different from proposed Insured)

b. Has there been or will there be any change in any existing insurance inforce?

☐Yes ☐No

c. Will premiums for the insurance applied for be paid by a policy loan from any existing policy?

☐Yes ☐No If yes, please furnish details (name of company, policy number and amount of insurance being replaced):

_____

Reminder: It is usually disadvantageous to REPLACE existing life insurance policy(ies) with a new one. Some disadvantages are: You may not be insurable on standard terms • You may have to pay a higher premium in view of higher age • You may lose financial benefits accumulated over the years. Please note that in your own interest, we would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

Signature Of Payor ✓_____ **Date** _____

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