

POLICY ALTERATION FORM

General Information:

Policyholder/ Insured Name
Last Name *First Name* *M.I.*

Policy No. Date of Birth

Mobile No. Landline E-mail

Complete Address

Change of Payment Frequency:

Yearly Semi-Annual Quarterly Monthly

Change of Co-Insured (for applicable plans only):

Additional

Name of Co-Insured Date of Birth

Relationship

Change in Beneficiaries (for applicable plans only):

Additional

Name of New Beneficiary Date of Birth

Relationship

Plan Upgrade / Downgrade:

Product Name

Current Plan To New Plan Type
 New Plan Option

This request, together with the declarations made during the recorded telephone enrolment, shall be considered as the application for amendment on the Policy Contract that has been issued by the Insurance Company to the Policyholder.

The corresponding Amendment that will be issued to reflect the requested policy changes shall be deemed part of the Policy Contract.

However, if the Policy Contract has been replaced by re-issuing another Policy Contract in order to reflect the requested policy changes, the previously issued Policy Contract shall be deemed to be no longer enforceable, having been superseded by the replacement Policy Contract.

**Signature over Printed Name
of policyholder / Insured**

Date