

Non-Financial Amendment Form



In this form, *you* and *your* refer to the policy owner/plan holder while *we*, *us*, *our* and *the Company* refer to Sun Life of Canada (Phils), Inc. and/or Sun Life Financial Plans, Inc., both are members of the Sun Life Financial group of companies.

You hereby request the Company to effect the change/s indicated below.

PRINT clearly. Use BLACK ink.

1 General Information

Policy owner/Plan holder Name (Last Name, First Name, M.I.)/Company Name (applicable for group pension plan)
Policy/Plan Number/Group Contract No.

2 Details of Change(s) Requested

Attach the original or certified true copy of the supporting legal document. Original copy will be returned after processing.

Name Change Request

Name Change For: <input type="checkbox"/> Policy Owner/Plan Holder <input type="checkbox"/> Life Insured <input type="checkbox"/> Beneficiary <input type="checkbox"/> Company/Business <input type="checkbox"/> Others, specify _____			
Original Name/Company Name (Last Name, First Name, Middle Name) as shown in the Company records			
New Last Name/Company Name		New First Name	
New Middle Name		New Other Legal Name(s)	
Permanent Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable			
Present Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable			
Home Phone (country code, area code & tel. no.)	Work Phone (country code, area code & tel. no.)	Mobile Phone (country code & mobile no.)	E-mail Address
Reason for Change: <input type="checkbox"/> Marriage <input type="checkbox"/> Legal Separation <input type="checkbox"/> For Correction <input type="checkbox"/> Others, specify _____			

Other Requests: Applicable for Educational Plan only and if Payor is not the Plan holder of the pension or educational plan

Request For	<input type="checkbox"/> Change	<input type="checkbox"/> Scholar	<input type="checkbox"/> Appointment	<input type="checkbox"/> Scholar
	<input type="checkbox"/> Payor		<input type="checkbox"/> Payor	
Original Name (Last Name, First Name, Middle Name as shown in the Company records)				
New Last Name			New First Name	
New Middle Name			New Other Legal Name(s)	
Permanent Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable				
Present Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable				
Birthdate (day/month/year)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Relationship to Plan holder	



Other Changes:

Change For:	From	To
<input type="checkbox"/> Countries of Legal Residence other than the Philippines	_____	_____
<input type="checkbox"/> Citizenship	_____	_____
<input type="checkbox"/> Contact Information	_____	_____
<input type="checkbox"/> Others, specify _____	_____	_____

Beneficiary Change

Change is for (Please check appropriate box):

Individual Insurance
 Pre-Need Plan
 Optional insurance riders attached to pre-need plan:
 GYRT
 PAP
 FAP
 SAP
 Others, specify: _____

Irrevocable Beneficiary/ies - If any beneficiary/ies is designated as irrevocable, your exercise of any right provided by the policy, except any right provided by the Dividends Provision and Special Paid-up Bonus, if any, will be subject to the consent of any beneficiaries designated as irrevocable beneficiaries while they exist.

Any designated beneficiary who is a minor at the time of pay-out of insurance proceeds/pre-need plan benefits and those minors who are designated as irrevocable beneficiaries are subject to the laws protecting minor.

The consent of a designated irrevocable beneficiary(ies), whether he/she is a minor or of legal age (i.e. 18 years old and over) is required for any policy transactions.

You request that the beneficiary/ies presently nominated to receive the proceeds due on death of the life insured/plan holder/scholar/member be changed to:

Primary Beneficiary/ies

Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Revocable/Irrevocable
Relationship to the life to be insured <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Others, specify _____	Country of Birth	Citizenship/s
Address		

Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Revocable/Irrevocable
Relationship to the life to be insured <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Others, specify _____	Country of Birth	Citizenship/s
Address		

Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Revocable/Irrevocable
Relationship to the life to be insured <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Others, specify _____	Country of Birth	Citizenship/s
Address		

Unless specified as irrevocable, beneficiaries may be changed.

Contingent Beneficiary/ies (in the event of death of all primary beneficiary/ies)

Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Relationship to the life insured
Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Relationship to the life insured
Name (Last Name, First Name, M.I.)	Birthdate (day/month/year)	Relationship to the life insured

3 Acknowledgement and Agreement

Changes to Material Facts or Personal Information

By affixing your signature below, you acknowledge and agree that you shall notify the Company in writing and provide the required details or documents within thirty (30) days for any changes in your personal/material information which results in the Company being subject to tax reporting and withholding requirements under local and/or foreign laws applicable to you or your property. There is a change in your personal/material information if there is a change in your contact number(s), place of residence, citizenship, or other circumstance as defined under applicable laws.

Data Privacy

By signing below, you consent, as well as affirm that you are authorized to give consent on behalf of the beneficiary, for the collection, processing, use, storage and destruction of personal and sensitive personal information and any information related to you and your assignee and/or beneficiary in relation to the subject insurance policy/pre-need plan as well as its sharing, transfer and/or disclosure to any of the Company's branches, subsidiaries, affiliates, advisors and representatives, industry associations and third parties such as but not limited to outsourced service providers, external auditors, and local and foreign regulatory authorities in relation to any matter including but not limited to those involving anti-money laundering and tax monitoring, review and reporting, statistical and risk analysis, provision of any products, service, or offers made through mail/email/fax/SMS/telephone, customer satisfaction surveys; compliance with court and other lawful orders and requirements. You and your assignee and/or beneficiary hold the Company free and harmless from any liability that may arise from any transfer, disclosure, processing, collection, use, storage or destruction of said information.

This section must be signed by the policy owner/plan holder. The witness should be a disinterested person and his/her address should be provided.

Signature of Policy Owner/ Plan Holder X	Printed Name
Signature of Witness X	Printed Name
Address of Witness (no., street, municipality/city, province, country, zip code)	
Place of Signing	Date of Signing (day/month/year)

Signature of Irrevocable Beneficiary, if any X	Printed Name	Place and Date of Signing (day/month/year)
Signature of Irrevocable Beneficiary, if any X	Printed Name	Place and Date of Signing (day/month/year)
Signature of Irrevocable Beneficiary, if any X	Printed Name	Place and Date of Signing (day/month/year)
Signature of Assignee, if any X	Printed Name	Place and Date of Signing (day/month/year)
Signature of Witness X	Printed Name	
Address of Witness (no., street, municipality/city, province, country, zip code)		
Place of Signing	Date of Signing (day/month/year)	

4 For Company Use Only

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