

# MoneyPlus Protection Plan

**15-DAY  
FREE LOOK  
GUARANTEE**

I understand that this does not obligate me in any way & that I will have the 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 and good health.

**Please Print (Full Name of Payor)**

Mr.	Mrs.	Ms.			
			First Name	M.I.	Last Name
Address					
Zip Code		Tel. No.		Mobile No.	
Email Address					
Date of Birth		Place of Birth		Age	Height
Male	Female				
Occupation			Specific Duties		
Buss. Address					
Zip Code		Office Tel. No.			
Full Name of Beneficiary <i>(For Life Benefit of Scholar)</i>					
Relationship to You <i>(Must be Next of Kin)</i>					
Revocable			Irrevocable		
Source of Funds					
TIN		SSS		GSIS	

**In case of premium default, I elect:**

Cash Surrender	Automatic Premium Loan	Cash Loan	Paid-Up Insurance Option
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*The moment there is a default in premium payment until the end of the grace period provided in the policy and no option has been elected, the Extended Term Insurance option shall automatically take effect.*

**Please check the plan you require:**

Plan 100	Plan 300	Plan 500	Plan 1000
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**PLEASE CHECK "YES" OR "NO" TO EACH QUESTION**

YES NO

Have you 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 impairment 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**

*I understand that the The Money Shield Policy will be issued based on the above statements which I represent are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, clinic or other medically related facility to furnish Paramount Life & General Insurance Corporation with any and all information regarding my medical history and physical condition in connection with this application.*

**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)*

Has there been or will there be any change in any existing insurance inforce?	Yes	No
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.

**Data Privacy Act**

I hereby consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, customer/client profiling, and disclosure to third parties, by Paramount Life & General Insurance Corporation (hereafter, "PLGIC"), its subsidiaries, affiliates, directors, officers, employees, and agents (a) to verify and/or confirm any or all the information provided or representation made, (b) to provide, facilitate, monitor, improve the quality of, or otherwise service my account and such products, services, and facilities and/or channels availed by me or may be offered by PLGIC, (c) for marketing purposes, and (d) to comply with legal, regulatory or other obligations of PLGIC under applicable local or foreign laws, rules and regulations.

I likewise consent to the processing of the personal data stated above whether manually or via electronic channels, including but not limited to the collection, usage, storage, and customer/client profiling, by authorized third parties for the foregoing purposes.

Such processing may be conducted for the duration of my availment of PLGIC's products, services, facilities and/or channels. I further consent that the personal data stated above shall be retained by PLGIC for an additional period of at least five (5) years, or for a longer period if the personal data is related to or required to be preserved for litigation or to comply with legal or regulatory requirement. I likewise consent to the correction, amendment, deletion and/or disposal by PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties, of my personal data which may be inaccurate or incorrect.

I attest that I have been made aware of and understood my rights as data subject and how these can be exercised, and that I was informed of the nature, extent and processing of the personal data I provided. I understand and agree that the consent hereby given may be revoked or withdrawn through formal written notice to PLGIC.

Finally, I authorize PLGIC, its subsidiaries, affiliates, directors, officers, employees, agents, and authorized third parties to obtain such other information they may deem necessary to verify or confirm the personal data declared or the documents furnished in relation to this application, and that I agree that such documents may remain in the possession of PLGIC whether or not this application is granted, for the purposes above mentioned.

Applicant's Signature

*(SIGN - DO NOT PRINT)*

Date

For inquiries or concerns relating to the privacy and security of your personal data or information submitted to Paramount Life & General Insurance Corporation (PLGIC), please contact the office of the Data Protection Officer (DPO) thru the following:

**The Data Protection Officer**  
15th Floor, Sage House Building  
110 V.A. Rufino Street, Legaspi Village,  
Makati City 1229

E-mail: [dataprotectionofficer@paramount.com.ph](mailto:dataprotectionofficer@paramount.com.ph)  
Tel. No.: +632 772 9267  
Mobile Nos.: +639176764846

A department of:

