



The Insular Life Assurance Company, Ltd.
Insular Life Corporate Centre, Insular Life Drive
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**WEALTH SERIES
APPLICATION FOR
COOLING-OFF**

Policy No:

1. INSURED				
Prefix	Given Name	Surname	Suffix	Suffix Title
2. POLICY OWNER				
Prefix	Given Name	Surname	Suffix	Suffix Title

REASON FOR COOLING-OFF: _____

I/WE HEREBY DECLARE AND AGREE THAT:

1. Insular Life will be fully discharged from all liabilities if my/our application for cooling-off refund on my/our policy is approved.
2. If Insular Life receives my/our application before the applicable cut-off time, the Company will use the unit price for that pricing date to sell units in my/our account/s. Otherwise, if received after the applicable cut-off time, the Company will use the unit price for the following pricing date. The Company has the sole discretion in determining the frequency of valuation, but said valuation will not be less frequent than weekly. The price for a particular pricing date will only be known at least one business day after the pricing date.
3. A request for cooling-off refund will terminate this Policy.
4. Withdrawal of application for cooling-off is not allowed.
5. This application for cooling-off will not be approved if any transaction, such as Top up, Fund Switch, has been made within the cooling-off period.

Signed this _____ day of _____, _____ at _____

POLICY OWNER
Printed Name and Signature

IRREVOCABLE BENEFICIARY
Printed Name and Signature

WITNESS/AGENT
Printed Name and Signature

ASSIGNEE/S
Printed Name and Signature

FOR HOME/FIELD OFFICE USE ONLY

RECEIVED BY: _____ **Office:** _____ **Date:** _____ **Secrets Number:** _____
Printed Name and Signature

Approved by: _____ **Office:** _____ **Date:** _____
Printed Name and Signature

HOME OFFICE ENDORSEMENT: