UNIVERSAL LIFE

APPLICATION FOR ALTERATION OF LIFE POLICY

POLICY NO:	**Policy Date:**
FULL NAME OF INSURED:	**I.C. No.:**
OCCUPATION AND SPECIFIC DUTIES OF INSURED PERSON:	
FULL NAME OF OWNER:	**I.C. No.:**

I hereby request the following alterations on my above numbered policy with effect as from (please insert date) ……

IT IS AGREED THAT : Universal Life will effect the following alterations by either terminating the present policy and replacing it by a new one with the requested alterations or by effecting the alterations on the present policy by endorsement as the case may be.

DECLARATION:

1. I hereby declare that no change has occurred regarding my health, since the submission of my application for the issue of the above numbered policy except as stated herebelow.

Illness, Operation or Accident , Tests or X-Rays	Name of Attending Doctor	Date	Details of Treatment and Results
Name and Address of Personal Doctor			
When did you last visit your doctor and for what ailment? Give name and address if other than your personal doctor.			
State your Height and Weight		Height	Weight
Has there been any weight variation since the submission of your application for the issue of the above policy? YES ☐ NO ☐		If YES please give the reason.	
For Women Only: Are you pregnant? **YES** ☐ **NO** ☐ If **YES** at which month?			

2. I hereby declare that no change has occurred in my daily activities or occupation, since the submission of my application for the issue of the above policy, which may increase the risk except as stated herebelow:

CHANGES IN EVERYDAY ACTIVITIES / OCCUPATION / DUTIES :

3. All above statements are, to the best of my knowledge and belief, correct and true. The alteration of my above policy, will be according to these statements and any other information which may be required by Universal Life.

AUTHORISATION:

I hereby authorise any doctor, hospital, clinic, insurance company or any other person to give any information which may be required by Universal Life

REQUIRED ALTERATION

DETAILS OF PREMIUM (PAYABLE AMOUNT/FREQUENCY/MODE OF PAYMENT)	**FROM**	**TO**
Alteration of Payable Premium (Only for UniOptions)	€	€
Alteration of Frequency of Premium Payment (Annually, Semi-Annually, Quarterly, Monthly)		
Alteration of Mode of Payment (Cash or Direct Debit)		

DETAILS OF ALTERATION IN RESPECT OF THE BASIC BENEFIT	**From €**	**To €**
Basic Sum Assured		
Alteration of Basic Premium		
IN CASE OF INCREASE OF THE BASIC PREMIUM PLEASE STATE THE REASON	**REASON:**	

RIDERS AND SUPPLEMENTARY BENEFITS	Note by ✔		Effective Date	**From**			**To**		
	Addition	Deletion		Premium €	Years	Sum Assured €	Premium €	Years	Sum Assured €
Ruler	**SEE SPECIAL APPLICATION**								

Signature of Insured Person : ..... Date: ……..

Signature of Owner of Policy :…… ..... Date: ……..

Signature of Witness to the above signatures : ……..... Date:……..

FOR INTERNAL USE

IN CASE THAT THE REQUIRED INCREASE OF THE PAYABLE PREMIUM IS GREATER THAN 100% AND/OR GREATER THAN THE YEARLY AMOUNT OF €1.500 THE FOLLOWING SHOULD BE COMPLETED BY THE AGENCY MANAGER.

I have checked the client's request and it is justified		Explain why:
I have checked the client's request and it is not justified		Explain why:

MANAGER'S SIGNATURE **Date:**

Name of Insurance Intermediary:	Code No.:
Amount Paid with Application:	CRS No:
Date of Payment Receipt by Agent:	CRS Date:
Paid to Date:	Billing Mode & Payment Code:
Reversal of premium:	Pending Transaction:
Face Change:	WPB:
Mode of Addition:	
Underwriting Terms	
Remarks:	