GROUP POLICY NO. 9900360260

BPI AIA LIFE ASSURANCE CORPORATION
(formerly BPI PHILAM LIFE ASSURANCE CORPORATION)
15F BPI-Philam Makati, 6811 Ayala Ave.,
Makati City 1226, Philippines
Tel No. (632) 8528 5501
TIN No. 000-318-213-000

(Herein called the "Company")

HEREBY ISSUES this Group Policy (herein called the "Policy") to

BPI ASSET MANAGEMENT AND TRUST CORPORATION / BPI WEALTH - A TRUST CORPORATION

(Herein called the "Assured")

AND AGREES, subject to all the terms and conditions stipulated hereafter, to pay at any of our offices the benefits as indicated in the Insurance Schedules and Benefit Provisions of this Policy, and of any Supplementary Contracts whose form number and description appear in the following table and are attached hereto:

Form No.	Form Description
CAC14BP	Life Insurance Benefit
	Critical Illness
	Hospital Income Benefit – Illness and Accident

IN WITNESS WHEREOF, BPI AIA has caused this Policy to be executed at Makati, Philippines, as of **November 01, 2024**, which is the Effective Date of this Policy.

Signed at our Home Office on the Effective Date.

Katherine P. Custodia

KAREN CUSTODIA
Chief Executive Officer

IMPORTANT NOTICE

THE INSURANCE COMMISSION, WITH OFFICES IN MANILA, CEBU AND DAVAO, IS THE GOVERNMENT OFFICE IN CHARGE OF THE ENFORCEMENT OF ALL LAWS RELATED TO INSURANCE AND HAS SUPERVISION OVER INSURANCE COMPANIES AND INTERMEDIARIES. IT IS READY AT ALL TIMES TO ASSIST THE GENERAL PUBLIC IN MATTERS PERTAINING TO INSURANCE. FOR ANY INQUIRIES OR COMPLAINTS, PLEASE CONTACT THE PUBLIC ASSISTANCE AND MEDIATION DIVISION (PAMD) OF THE INSURANCE COMMISSION AT 1071 UNITED NATIONS AVENUE, MANILA WITH TELEPHONE NUMBERS +632-5238461 TO 70 AND EMAIL ADDRESS pubassist@insurance.gov.ph. THE OFFICIAL WEBSITE OF INSURANCE COMMISSION IS www.insurance.gov.ph.

THIS CONTRACT IS BETWEEN THE ASSURED NAMED IN THIS POLICY AND BPI-PHILAM LIFE ASSURANCE CORP., A SUBSIDIARY OF PHILAM LIFE AND AN AFFILIATE OF THE BANK OF THE PHILIPPINE ISLANDS (BPI). ALL TRANSACTIONS ARISING OUT OF OR RELATED TO THIS CONTRACT SHALL BE BINDING ONLY BETWEEN THESE TWO (2) CONTRACTING PARTIES. IT IS UNDERSTOOD THAT THIS TRANSACTION IS NEITHER INSURED BY THE PHILIPPINE DEPOSIT INSURANCE CORPORATION NOR GUARANTEED BY BPI.

DOCUMENTARY STAMPS CORRESPONDING TO THE INSURANCE UNDER THIS POLICY ARE AFFIXED AND CANCELLED ON THE DUPLICATE OF THIS POLICY.

GENERAL PROVISIONS

PRONOUNS

Any pronouns used in this Policy, and any Supplementary Contracts or endorsements attached hereto, shall, when applicable, apply to either gender. The words "we", "us", "our" and "the Company" refer to us, BPI-Philam Life Assurance Corp.

DEFINITION OF "MEMBER"

The term "Member" as used in this Policy, and any Supplementary Contracts or endorsements attached hereto, shall mean any person who is eligible, enrolled and insured for benefits provided under the contract.

CONTRACT

This Policy is issued in consideration of the application of the Assured, a copy of which is attached hereto, and of the payment of the required initial premiums by the Assured.

The entire contract is composed of this Policy, any Supplementary Contracts or endorsements attached hereto, the application of the Assured, the individual applications of the Members, any amendments to the contract duly signed by the Assured and the Company, and other relevant policy forms.

The contract may at any time be amended and changed as long as compliant with pertinent regulations and guidelines or with approval of the Insurance Commission, if needed, and evidenced by an endorsement or by an amendment signed by the Assured and by the Company. Any such amendment shall be binding on all Members under this Policy whether they became insured on or after the effective date of the amendment.

No agent is authorized to alter or amend the contract, to accept premiums in arrears or to extend the due date of any premium, to waive any notice or proof of claim required by the contract, or to extend the date before any such notice or proof must be submitted.

All statements made by the Assured or by any Member shall be deemed representations and not warranties. No statement made by any Member shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such Member or to his Beneficiary.

The contract shall be in the possession of the Assured, and shall be made available to Members for inspection at any time during its business or office hours at its office.

INCONTESTABILITY

This Policy and any coverage provided hereunder shall be incontestable after one (1) year from its effective date or latest reinstatement date, whichever is later, except for non-payment of premiums or for any other grounds recognized by law and jurisprudence, among others. This contestability period shall likewise apply to any statement made by a Member relating to his insurability under this Policy.

Where benefits are not payable because of this provision, our liability shall be limited to the refund of premiums for the contested coverage to the Assured and/or Member.

DATA REQUIREMENTS

The Assured shall furnish promptly in writing, on forms satisfactory to us, all notices and information required for the efficient administration of the insurance under the contract, including:

(a) notice of all proposed Members, together with information necessary to determine the age, amount of insurance, effective date of insurance, and name and relationship of the Beneficiary, if any;
(b) the name of each Member whose insurance has terminated and the date of such termination, except in the case of the termination of this Policy, of a Supplementary Contract or of an endorsement; and
(c) notice of changes in the insurance classification of any Member.

All documents and records of the Assured, including those furnished by a Member, which have a bearing on the insurance under this contract, shall be open for inspection by the Company at all reasonable times.

CLERICAL ERROR

Clerical error in keeping the records of the Assured shall not invalidate the insurance otherwise validly in force, nor continue insurance otherwise validly ineligible or terminated.

MISSTATEMENT OF INSURANCE DETAILS

If the age, date of birth or other relevant facts relating to a Member shall be found to have been misstated, and if such misstatement affects the eligibility and amount of insurance of such Member, the correct age and facts shall be used to determine whether such Member is insurable under this Policy, or any Supplementary Contracts attached hereto, and in what amount. In such case of misstatement, an equitable adjustment of premiums and of benefits payable shall be made if necessary.

However, if according to the correct insurance details, the Member is not eligible for coverage under this Policy, or any Supplementary Contracts attached hereto, the liability of the Company shall be limited to the refund of premiums for such ineligible coverage to the Assured and/or Member.

PREMIUMS AND RENEWAL

The initial premium for each benefit provided in this Policy, and any Supplementary Contracts attached hereto, shall be stated in the Premium Rate provision applicable to such benefit, shall apply for its first policy year, and is due and payable on its effective date.

This Policy, and any Supplementary Contract attached hereto, may then be renewed at the commencement of each new policy year for a further term of one (1) year by payment of the required premiums when due, subject to the minimum Participation Rate and minimum number of Member, as indicated in the Member Contribution and Participation provision of this Policy.

Renewal premiums shall be based on the Company's premium rate effective at the time of such renewal, subject to the Company's right to decline renewal of this Policy, or of any Supplementary Contracts attached hereto, on any policy anniversary upon giving forty-five (45) days prior written notice to the Assured indicating the Company's intention not to renew, including the basis for non-renewal, or to condition renewal upon reduction of limits, increase in premium, or elimination of coverages.

The premium due on any premium due date for the premium period commencing with such due date and ending with the next succeeding due date shall be the aggregate of the premiums for all individual coverages in force at the beginning of such premium period. Premiums are payable by the Assured to any of the offices of the Company.

A statement of premiums due, including premium adjustments, will be furnished by the Company as of each due date. Premium adjustments shall be made as mutually agreed upon by the Assured and the Company or, if no such agreement is made, on the first (1st) day of each month coinciding with or immediately following the effective date of enrolment, termination, or change of insurance of any Member which results to such adjustments. Premium adjustments involving a return of unearned premiums to

the Assured shall be limited to the period of twelve (12) months immediately preceding the date of receipt by the Company of evidence that such adjustments should be made.

EXPERIENCE RATING

Premiums shall be subject to reductions, increases or any other adjustments as the Company may make on any policy anniversary, for the year then commencing, under its experience rating plan in effect on such anniversary, if any. In addition to, or in lieu of a reduction in premium rates at the beginning of any policy year, the Company may make a retroactive rate reduction from the previous year with a consequent refund of premium for that year, contingent upon renewal and payable to the Assured in cash or otherwise applied in such manner as may be mutually agreed upon. Payment of any refund or its equivalent application shall be based on pro-rata sharing of premiums by the Assured and Members, and such payment shall completely discharge the liability of the Company with respect to the refund so paid or applied. No increase in premium rate shall be retroactive.

GRACE PERIOD

Except for the initial premium, each premium may be paid even after it has become due, but not later than a Grace Period of thirty-one (31) days following its due date. If the premium due is not paid within the Grace Period, the insurance coverage under this Policy, or any Supplementary Contract attached hereto, relating to such premium shall automatically discontinue at the expiration of the Grace Period. However, if the Assured has given the Company written notice in advance of an earlier date of discontinuance, the insurance coverage shall discontinue as of such earlier date. The Assured then shall be liable to the Company for the payment of a pro-rata premium for the time the insurance coverage has been in force during the Grace Period.

For any loss occurring within the Grace Period, the corresponding benefit shall be reduced by any unpaid premium due relating to such benefit.

TERMINATION OF GROUP INSURANCE

This Policy shall automatically terminate on the earliest of the following dates:

(a) the date the premium falls due if a written notice that this Policy will not be renewed is given to the Company by the Assured on or before such premium due date;
(b) the date of receipt by the Company of the Assured's written notice to terminate this Policy, if such notice is given within the Grace Period;
(c) the date following the end of the Grace Period if the premium for this Policy is not paid; or
(d) the date of the Company's written notice of termination to the Assured due to its failure to meet either the minimum Participation Rate or the minimum number of Members, as indicated in the Member Contribution and Participation provision of this Policy.

Termination of this Policy for any cause shall be without prejudice to any claim arising prior to the effective date of termination of insurance hereunder.

All or any part of any premium which are accepted by the Company after the termination of this Policy or which could no longer be applied because of such termination will be refunded to the Assured, and will not create any liability on the Company unless this Policy is reinstated or has been reinstated in the meantime, pursuant to the Reinstatement provision of this Policy.

SUICIDE

If a Member dies by suicide within one (1) year from the effective date or latest reinstatement date, whichever is later, of such Member's individual insurance coverage, the Company's liability shall be limited to a return of premiums paid for such Member's coverage. However, suicide committed in a state of insanity shall be compensable regardless of the date of commission.

PROOF OF COVERAGE

The Company will issue to the Assured, for delivery to each Member under this Policy, an individual proof of coverage setting forth a summary of the essential features of the insurance coverages and other privileges to which such Member is entitled, and stating to whom the benefits are payable.

This proof of coverage does not constitute a contract, but merely contains informative statements setting forth the benefits and the claims procedures. In case of any inconsistency between a proof of coverage and the contract, the contents of the contract shall prevail.

The individual proofs of coverage and the corresponding benefits are not transferable.

CURRENCY AND PLACE OF PAYMENT

All amounts payable either to or by the Company will be in Philippine Peso (PHP) only. All amounts payable by the Company will be paid only in the Philippines. The contract will be governed by and interpreted according to the laws of the Philippines.

Article 1250 of the Civil Code of the Philippines (Republic Act No. 386) which reads: *"In case an extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis for payment."* will not apply to any payments made or to be made to or by the Company.

TAXES

Any deficiency in taxes which may now or in the future be due on the contract shall be for the account of the Assured.

LIMITATION OF ACTION

Unless a claim has been rejected, no legal action may be filed before the end of five (5) years after proof of loss has been filed in accordance with the applicable provisions of this Policy, and of any Supplementary Contracts or endorsements attached hereto. In any event, no legal action may be filed after one (1) year from the time the claim is denied or decided. The venue of any legal action relating to the contract shall not be limited to its place of issue.

NON-PARTICIPATING

This Policy, and any Supplementary Contract attached hereto, shall be non-participating and shall not share in the surplus earnings of the Company.

ASSIGNMENTS

No assignment of this Policy, or any Supplementary Contracts attached hereto, shall be binding upon the Company unless with the written conformity of the Assured through its authorized representative, and until filed at any of the offices of the Company.

No assignment by any Member of any insurance under this Policy, or any Supplementary Contract attached hereto, shall be valid. Any assignment by the Beneficiary subsequent to the death of the Member shall not be binding upon the Company until the original assignment, or duplicate thereof, is received at any of the offices of the Company, and the assignment is acknowledged in writing by the Company prior to the payment of the proceeds.

The Company assumes no responsibility for the validity or effect of any such assignment made in accordance with this provision.

REINSTATEMENT

This Policy, and any Supplementary Contracts attached hereto, may be reinstated if it has lapsed for non-payment of premium, subject to the Assured's payment of all back premiums due, including interest, and its compliance with the reinstatement requirements of the Company, which may include evidence of insurability, at the time of such reinstatement.

NOTICE

Written notice given by the Company to an authorized representative of the Assured is deemed notice to all affected Members in the administration of this Policy, including termination of this Policy. The Assured is responsible for giving notice to Members.

APPLICABLE LAW

This Policy, and all rights, obligations and liabilities arising hereunder, shall be construed and determined and may be enforced in accordance with the law of the Place of Issue.

LEGAL PROCEEDINGS

No action in law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirement of this Policy, nor shall such action be brought at all unless brought within two (2) years from the expiration of time within which proof of loss is required by this Policy.

OBLIGATIONS OF THE POLICYHOLDER

The Assured is obliged of the following commitments to this Policy, and any Supplementary Contracts attached hereto:

1. To contract with insurance company for the coverage of individual members under a group policy taking into consideration the best interest of its members;
2. To negotiate for a reasonable premium which its members may partially or fully pay;
3. To distribute to the insured members the statement, proof of cover, confirmation or certificate issued by the insurer;
4. To make available to the insured for reading or copying the master policy and relevant documents and provide a copy thereof in paper or electronic form in an amount not exceeding the cost of reproduction or delivery;
5. To collect from the insured person an amount not higher than the amount of premiums indicated in the policy;
6. To faithfully remit to the insurer the amount collected as premium;
7. To maintain the list of insured members or documents to prove individual membership or enrollment;
8. To assist the insured person or beneficiary in the processing of claims and submission of documents to the insurer;
9. To support individual insured or beneficiary in the filing of cases relevant to the non-payment of claims;
10. To inform the active members of the impending cancellation of the group policy by the insurer upon its receipt of the notice; and
11. To inform the covered members of the fact of issuance and important contents of any endorsement or rider issued after the issuance of the group policy which shall be agreed upon by the policyholder and the insurer.

INSURING PROVISIONS FOR MEMBERS

ELIGIBILITY

For Non- Employer- Employee Groups:

(a) Any Person who is a BPI Wealth Builder Fund Investor
(b) Any Person who has reached the minimum investments or fund value of Php 400,000, whichever is higher.
(c) Any person who is aged 18-65 years old, terminates at age 66.
(d) In good standing, good health and actively performing the "daily normal chores of life."

"Daily normal chores of life" shall refer to the performance of daily routine task (such as batching, cooking, walking and etc.) solely independently of others.

ENROLMENT

Written enrolment, on forms satisfactory to the Company, is required for each eligible person applying as Member for insurance coverage under this Policy, or any Supplementary Contracts.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE

The insurance for a proposed Member shall become effective on the applicable date set forth below:

1. If no contributions from Members are required, on whichever is the latest of:
   (a) the Effective Date of this Policy;
   (b) the date on which he first meets the eligibility requirements stated in the Eligible Persons provision of this Policy; or
   (c) in the case of a benefit added to this Policy at a date later than the Effective Date of this Policy, the effective date of such benefit or the date on which he first meets the eligibility requirements for such benefit, whichever is later.
2. If contributions from Members are required, on whichever is the latest of:
   (a) the Effective Date of this Policy;
   (b) in the case of a benefit added to this Policy at a date later than the Effective Date of this Policy, the effective date of such benefit or the date on which he first meets the eligibility requirements for such benefit, whichever is later; or
   (c) the date of the Member's enrolment, provided that:
      (i) when the enrolment date is more than one (1) month after the Effective Date of this Policy or the date on which he first becomes eligible, whichever is later; or
      (ii) when he is a previous Member who has voluntarily terminated his insurance under this Policy but has remained eligible for insurance applies for reinstatement

   he shall furnish at his own expense evidence of insurability satisfactory to the Company in addition to a properly completed application, and his insurance shall not become effective until the date of approval by the Company, at any of its offices, of such application and evidence of insurability.

However, if the proposed Member is, on account of injury or disease, not actively a BPI Wealth Builder Fund Investor on the date his insurance would otherwise have become effective as provided above, the insurance shall not become effective until the date he returns to as an active BPI Wealth Builder Fund Investor .

"Activities of Daily Living", as used in this Policy, shall have the following meanings:

(a) Transfer – getting in and out of a chair without requiring physical assistance.
(b) Mobility – the ability to move from room to room without requiring any physical assistance.
(c) Dressing – putting on and taking off all necessary items of clothing without requiring assistance of another person.
(d) Bathing/Washing – the ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by other means.
(e) Eating – all tasks of getting food into the body once it has been prepared.
(f) Toileting – the ability to use the toilet.

MEMBER CONTRIBUTION AND PARTICIPATION

A Member shall not contribute towards the cost of his insurance under this Policy. This shall apply to any Supplementary Contracts attached hereto, unless otherwise agreed upon by the Company and the Assured.

The minimum number of Members required to be covered under this Policy shall be ten (10).

The minimum Participation Rate, which is the ratio of covered Members to eligible persons, for this Policy shall be one hundred percent (100%).

In case of refund of premiums to the Assured for any cause provided in this Policy, or any Supplementary Contracts attached hereto, and a Member contributes part of the premium for the coverage the refund relates to, he shall be entitled to a portion of the refunded premiums proportionate to his contribution to the total premium for such coverage.

CHANGE IN INSURANCE CLASSIFICATION OR AMOUNT

If more than one classification is designated in any of the Insurance Schedules, a Member shall be insured for the benefits applicable to his classification on the effective date of such insurance. Thereafter, if his classification or insurance coverage changes on account of a benefit upgrade, the insurance or any increase in the amount of insurance of such Member shall be changed on November 01 (hereafter referred to as Insurance Change Date), except that when he is, on account of injury or disease, not actively a BPI Wealth Builder Fund Investor on such date, the benefits applicable to him shall not be changed until the date on which he returns to as an active BPI Wealth Builder Fund Investor.

The Assured shall notify the Company of all such changes in insurance classification or amount within one (1) month after the Insurance Change Date, and the Assured shall pay the required premiums from the Insurance Change Date for the revised insurance resulting from such changes. If individual contributions are required under this Policy, the Assured shall make the necessary adjustment in such contributions with respect to all Members affected by such changes.

CHANGE IN OCCUPATION OR DUTIES

If a Member sustains a loss after having changed occupation or duties to one classified by us as more hazardous than that stated in the Member's application, or while doing, for compensation, anything pertaining to an occupation or duties so classified, we will pay only such portion of the indemnities provided in this Policy, or any Supplementary Contract attached hereto, as the premium paid would have purchased at the rates and within the limits fixed by us for such more hazardous occupation or duties.

If a Member changes occupation or duties to one classified by us as less hazardous than that stated in the Member's application, we, upon receipt of proof of such change, will reduce the premium rate accordingly, and will return the excess pro-rata premium from the date of such change, or from the date of issue or last renewal of this Policy, or any Supplementary Contract attached hereto, prior to the receipt of such proof, whichever is later.

In applying this provision, the classification of occupation or duties and the premium rates shall be such as existing at the date of issue or last renewal of this Policy, or any Supplementary Contract attached hereto, prior to the occurrence of the loss for which we are liable or to the date of receipt of proof of such change, whichever is later.

TERMINATION OF INDIVIDUAL INSURANCE

The insurance of a Member under this Policy shall automatically terminate on the earliest occurrence of the following dates:

(a) the date this Policy terminates, in accordance with the Termination of Group Insurance provision of this Policy;
(b) the date of payment of due premiums for which the premium on account of the Member's insurance is intentionally and specifically not paid by the Assured;
(c) the date the Member enters military, naval or air service;
(d) the date the Member ceases to be eligible for insurance under this Policy;
(e) the date of the Member's death;
(f) if Sub-Group Provisions are made part of this Policy, the date on which the insurance for the Member's Sub-Group terminates;
(g) the anniversary of this Policy nearest the Member's sixty-fifth (65th) birthday; terminates at age 66.
(h) the date the Member is retired, pensioned, resigned voluntarily, or dismissed from the employment of the Assured, or the date the Member otherwise ceases active work for the Assured; provider however that, in the event of disability, temporary layoff or approved leave of absence, payment of the required premium will continue the insurance in force for a limited period commencing with the date the Member ceases active work and automatically terminating on the earliest of the following dates:
    (a) in the event of disability, the end of the period of disability;
    (b) in the event of temporary layoff or approved leave of absence, the end of one (1) month with respect to any Medical Insurance provided under this Policy, and the end of three (3) months with respect to any other insurance provided under this Policy; or
    (c) the date the insurance terminates in accordance with the other occurrences under this provision.

TEMPORARY SUSPENSION OF INDIVIDUAL INSURANCE

Except as otherwise provided in the Termination of Individual Insurance provision of this Policy, contributions on account of the Member's insurance in this Policy, may be suspended by the Assured during a temporary absence from work for a period of not less than thirty-one (31) days and for a period of not more than two (2) years if absence is due to illness, or any other cause. The Assured must give due notice of such suspension to the Company. No insurance coverage will be provided to such Member during the period of suspension, and insurance coverage will be resumed following the period of suspension only on a date on which he is actually working in full-time employment with the Assured.

INSURANCE BENEFITS

The insurance benefits applicable to each Member shall be in accordance with the classifications, limitations and conditions as indicated in the Insurance Schedules and Benefit Provisions of this Policy, and of any Supplementary Contracts attached hereto.

BENEFIT PROVISIONS

LIFE INSURANCE BENEFIT

Upon receipt and approval by the Company of due proof of death of a Member, the Company will, subject to the limitations and provisions of this Policy, pay the applicable amount of Life Insurance Benefit as indicated in the Insurance Schedule of this Policy.

BENEFICIARY

The insurance benefits relating to the death of the Member under this Policy, and any Supplementary Contracts attached hereto, shall be payable to his designated Beneficiary or Beneficiaries, if surviving the Member, or if such designated Beneficiaries do not survive the Member, to the first surviving class of the following classes of beneficiaries in successive preference: the Member's (a) surviving spouse; (b) surviving children born to or legally adopted by the Member; (c) surviving parents; (d) surviving brothers and sisters. Should there be no Beneficiary or successive preference beneficiary surviving at the death of the Member, any death benefit shall be payable to the Member's estate. This successive preference for beneficiaries shall likewise apply if the Member does not designate any Beneficiary, or if there shall be no one occupying the status as Beneficiary upon the death of such Member.

An affidavit, signed by any individual belonging to the first surviving class of successive preference beneficiaries described in items (b), (c) or (d) in the preceding paragraph, stating the names and addresses of the persons belonging to such class, shall be sufficient proof to the Company that the person or persons so named therein are the sole survivors of such class. Payment by the Company based upon such affidavit shall be full acquittance hereunder.

Any amount payable to a minor in accordance with the provisions of the preceding paragraphs may, at the option of the Company, be paid to any surviving parent of, or to such person or persons who have, in the Company's opinion, assumed the custody and principal support of such minor.

All living benefits and indemnities provided under any Supplementary Contracts shall be payable to the Member.

Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

BENEFICIARY DESIGNATION

A Member shall designate his Beneficiary or Beneficiaries upon becoming insured hereunder. Such Member may at any time thereafter change the Beneficiary designation by filing with the Company a properly completed written request, on a form satisfactory to the Company; provided, however, that if any of the Beneficiaries is designated as irrevocable, the written consent of all such irrevocable Beneficiaries shall be included in the request for change in Beneficiary designation. Any such change shall take effect only upon receipt of such written request and recording in writing and approval by the Company. Written consent of all irrevocable Beneficiaries shall likewise be required before the Member can exercise any and all other rights and privileges provided to him under this Policy, or any Supplementary Contracts attached hereto.

Unless otherwise indicated the application, designated Beneficiaries shall receive benefit proceeds in equal shares.

NOTICE AND PROOF OF LOSS

Written notice and proof of loss must be submitted to the Company at its Home Office or in any one of its branch offices in the Philippines within thirty (30) days and ninety (90) days, respectively, after the Member's death. Failure to submit the notice or proof within such time shall not invalidate or reduce any claim if it shall be shown to have been not reasonably possible to do so, and that the notice or proof was submitted as soon as was reasonably possible.

SETTLEMENT OPTIONS

By giving proper written notice, any Member may elect, with the right to revoke or to change such election, to have the whole or any part of the amount which would otherwise be payable to himself or to his Beneficiary in a single sum paid in instalments or in any other manner that may be agreed to by the Company. The amount and terms of payment shall be in accordance with those customarily offered by the Company for group life insurance policies at the time of election. If the Member does not make an election, the Beneficiary may do so after the Member's death.

If any person dies while receiving instalment payments under such settlement option, the remaining instalments, unless otherwise disposed of, shall be commuted and paid, in a single sum, to the executors, administrators or assignees of such person. Any such payment will release the Company from all further liability to the extent of such payment.

INSURANCE SCHEDULE

The amount of Life Insurance Benefit per classification of Member shall be as follows:

Classification	Amount of Insurance (Php)
All Eligible Members	2,000,000.00

EVIDENCE OF INSURABILITY

The No Evidence Limit (NEL) for this Policy is Php 2,000,000.00, which is the maximum amount of insurance coverage for which any Member may be initially insured without submission of evidence of insurability.

Evidence of insurability satisfactory to the Company shall be required of any Member in respect of any amount of insurance in excess of the NEL, or in respect of any subsequent increases in the amount of insurance. However, no evidence of insurability will be required of Members who have previously submitted evidence, have been classified as standard and whose insurance is to increase by not more than twenty-five (25%) in a period of one year.

Such excess insurance or increase in the amount of excess insurance, which is subject to submission of evidence of insurability, shall become effective on the date of approval of the evidence of insurability by the Company. Furthermore, notwithstanding any payment of premiums under this Policy, no coverage in excess of the NEL shall be valid unless the evidence of insurability requirement is complied with by the Member and approved by the Company.

PREMIUM PROVISIONS

PREMIUM RATE

The initial premium rate for the Life Insurance Benefit provided under this Policy per classification of Member shall be as follows:

MODAL PREMIUMS

If premiums are payable under a mode of payment other than annual, the average annual rate shall be multiplied by to obtain the monthly, quarterly or semi-annual premium rates, respectively.

DOCUMENTARY STAMP TAX

The Documentary Stamp Tax (DST) on this Policy shall be for the account of the Assured. The Assured shall also shoulder any additional DST which may arise due to any change on the amount of insurance and/or number of covered Members.

EFFECTIVE DATE

The sections on Benefit Provisions and Premium Provisions are made part of this Policy and becomes effective on November 01, 2024.

CONVERSION PROVISION

If a Member's coverage under this Policy terminates because of termination of employment or transfer to a class of a person not eligible for insurance coverage under this Policy, the Member shall be entitled to have issued to him by the Company an individual policy of life insurance in any one of the forms then customarily issued by the Company (except a policy of term insurance, or a policy providing disability or other supplementary benefits) in an amount not exceeding the amount of his Life Insurance Benefit at the time of such termination.

Such individual policy shall be issued by the Company without evidence of insurability, upon his application made to the Company within thirty (30) days after such termination, and upon the payment of the premium applicable to the class of risk to which he belongs and to the form and amount of policy at his then attained age. If issued, such individual policy shall become effective on the expiration of the thirtieth (30^{th}) day following such termination, provided the corresponding premium is paid to the Company not later than such effective date.

In the event that this Policy is terminated or amended so as to terminate the insurance coverage of any class of Members, each Member belonging to such class shall be entitled to convert his insurance coverage under this Policy upon the same conditions as set forth in the foregoing paragraphs, provided that the Member has been insured under this Policy, or any group policy of the Company which it replaced, for at least five (5) years.

If the Member dies during the period within which he would have been entitled to have an individual policy issued in accordance with this Conversion Provision, the amount of insurance he would have been entitled to have issued under such individual policy shall be payable under this Policy whether or not application for the individual policy or the payment of the first premium therefor has been made. Benefit payment for this case shall be made to the Member's Beneficiary under this Policy, provided that the designation of a Beneficiary under such individual policy, or in the application therefor if such individual policy has not been issued, other than the Beneficiary under this Policy shall effect a change of Beneficiary hereunder to the Beneficiary designated under such individual policy.

Any Member who shall have exercised the conversion privilege herein granted may not be readmitted for life insurance under this Policy or under any group policy replacing this Policy without the production, at his own expense, of evidence of insurability satisfactory to the Company.

CRITICAL ILLNESS BENEFIT

BPI-AIA LIFE ASSURANCE CORPORATION
CRITICAL ILLNESS SUPPLEMENTARY CONTRACT (MEMBERS)
FOR GROUP YEARLY RENEWABLE TERM

This Supplementary Contract is attached to and made part of **Policy No. 9900360260.**

It is hereby agreed and understood that effective on (effective date)**,** Critical Illness Benefit is provided under this Supplementary Contract, subject to the following terms and conditions:

Part I – BENEFIT PROVISIONS

Section 1 – Payment of Benefits

Upon receipt by the Company of due proof of claim that a Member has been diagnosed by a qualified Physician to have contracted a Critical Illness as hereinafter defined, the Company will, subject to the limitations and provisions of the Policy and this Supplementary Contract, pay to the Member the Critical Illness Benefit specified in the Schedule for this Supplementary Contract.

In the event of an approval of any claim under the Total and Permanent Disability Supplementary Contract (Form No. CAC16BP) which may be attached to the Policy, coverage under this Supplementary Contract shall automatically terminate. However, in the event that a Member becomes eligible for Critical Illness and Total and Permanent Disability benefit at the same time, the Company shall only pay both benefits as specified in the Schedule.

Section 2 - Exclusions

The following exclusions shall apply to all Members under this Supplementary Contract:

1. No benefit shall be payable under this Supplementary Contract for any illness or surgery, other than a diagnosis of, or surgery for a Critical Illness defined herein.

2. No benefit shall be payable for any Critical Illness which was diagnosed prior to, or within the Waiting Period following the Effective Date or the latest date of any reinstatement of the respective Insured Member whichever is later.

3. No benefit shall be payable for any Critical Illness if the Member seeks medical advice or treatment for any signs or symptoms for such illness which, based on the findings of the Company, first manifested or occurred prior to, or within the Waiting Period following the Effective Date of Coverage or the latest date of reinstatement of the respective Insured Member whichever is later.

4. No benefit shall be payable for Coronary Artery Bypass Surgery if the Member had been diagnosed as suffering from “heart attack” prior to the Effective Date of Coverage or the latest date of reinstatement of the respective Insured Member whichever is later.

5. No benefit shall be payable for any Critical Illness which was diagnosed due, directly or indirectly, to a congenital defect or disease which has manifested or was diagnosed before the Member reached seventeen (17) years of age.

6. No benefit shall be payable under this Supplementary Contract for any Critical Illness caused directly or indirectly, wholly or partly, by
    a) self-inflicted injury; or
    b) addiction to alcohol or drugs not prescribed by a medical doctor; or
    c) while under the influence of alcohol or unprescribed drugs; or
    d) atomic or nuclear radiation; or
    e) Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), or
    f) pregnancy and resulting childbirth, miscarriage or abortion, or
    g) cosmetic or plastic surgery, except as a result of Injury; or
    h) war or any acts thereof; or
    i) homicide, frustrated homicide or any attempt thereof, or physical injuries; or
    j) automobile and motorcycle racing, judo, karate and similar martial arts, scuba diving, hang gliding and sky gliding;

Section 3 – Age Limitation

If at the Effective Date of this Supplementary Contract, the age of the Member at nearest birthday is more than sixty-fifth (65) years, this Supplementary contract shall be void and the Company shall be liable only for the return of premiums actually paid on it.

Section 4 – Notice of Claim

Written notice of claim must be presented to the Company at any of its offices or branches in the Philippines within thirty (30) days after a professionally confirmed diagnosis of the Member has been done and it manifesting that he has contracted a Critical Illness. Failure to give notice within such time shall not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give such notice and that such notice was given as soon as was reasonably possible.

The Company, upon receipt of the notice, will provide the necessary forms for filing proof of claim. These forms which give satisfactory proof of a professionally confirmed diagnosis of Critical Illness, must be submitted to the Company at its Home Office or in any one of its branch offices in the Philippines within ninety (90) days after the date of such Diagnosis of Critical Illness. If such forms are not provided within fifteen (15) days after receipt of notice of claim, the claimant shall be deemed to have complied with the requirements of these Benefit Provisions as to proof of claim upon submitting any other satisfactory written proof if filed within the required ninety (90) days.

Section 5 – Examination

The Company shall retain the right to have a Physician of its choice examine the Member before Critical Illness benefits are paid under this Supplementary Contract as often as it may reasonably require, during the pendency of a claim hereunder and during the entire period that the Company is liable to pay the benefit under this Supplementary Contract. The Company may also require the Member to undergo a blood test or other relevant tests including a test for HIV, as a condition precedent to the liability of the Company to make any payment.

Section 6 – Coordination of Critical Illness Benefits

The total amount of Critical Illness Benefits payable from this Supplementary Contract and other in-force critical illness policies and/or supplementary contracts issued by the Company shall be subject to the maximum limits set and prevailing at the time the Critical illness was diagnosed.

Should the total benefits payable from the Policy and from all in-force critical illness policies and supplementary contracts issued by this Company covering the Member exceed the limit, then the benefit under the last policy(ies) or supplementary contract(s) which gave rise to the excess shall be correspondingly reduced and a proportionate refund of the premiums paid on such portion of the benefit shall be made to the Member.

Part II - DEFINITIONS

The following words and phrases shall have the following meaning:

1. "Effective Date of this Supplementary Contract" shall mean the Effective Date of the Policy unless a different date is indicated.

2. "Supplementary Contract" shall mean this agreement as signed by the Company.

3. "Member" means any person who is eligible, enrolled and insured for insurance benefits provided for Members under the Policy. "Insured person" shall be deemed to include the term "Member".

4. "Waiting Period" refers to the length of time after the Effective Date of the Supplementary Contract or any Reinstatement, within which Critical Illness Benefits are not payable by the Company. Such Waiting Period can only be either ninety (90) days or one-hundred and eighty (180) days, as indicated in the Insurance Schedule attached hereto.

5. "Diagnosis" shall mean the definitive diagnosis made by a Physician, as hereinafter defined, based upon such scientific evidence, as referred to herein below in the definition of the particular Critical Illness concerned or, in the absence of such specific reference, based upon radiological, clinical, histological, laboratory or other diagnostic tests acceptable to the Company. Such includes the postmortem examination of the Member by the Company in the event of the sudden death of the Member, where it is not forbidden by law.

   In the event of any dispute or disagreements regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to call for an examination, of either the Member or the evidence used in arriving at such diagnosis, by an impartial acknowledged expert in the field of medicine concerned and the opinion of such expert as to such Diagnosis shall be binding on both the Member and the Company.

6. "Physician" shall mean a person legally licensed to practice medicine in the Philippines other than the Member, an insurance agent of the Company or a member of the Member's immediate family.

7. "War" shall mean invasion, or act of foreign enemy, hostilities or warlike operations (whether war be declared or not) mutiny, riot, civil commotion, strike, civil war, rebellion, revolution, insurrections, conspiracy, military or usurped power, martial law or state of siege, or any of the events or causes which determine the proclamation or maintenance of martial law or state of siege, seizure, quarantine, or nationalization by or under the order of any government or public or local authority.

8. "Acquired Immunodeficiency Syndrome (AIDS)" or "Infection by any Human Immunodeficiency Virus (HIV)" shall mean:

   a) The definition of AIDS shall be that used by the World Health Organization in 1987, or any subsequent revision by the World Health Organization of that definition, and

   b) Infection shall be deemed to have occurred where blood tests indicate, based on the findings of the Company, either the presence of Human Immunodeficiency Virus or the antibodies of such virus.

9. "Manifest/Manifestations" means the existence of symptom/s or sign/s of Critical illness or a condition likely to cause the Critical Illness which would cause an ordinary prudent person to seek diagnosis, care or treatment.

10. "Activities of Daily Living" shall have the following meanings:
    a) Transfer – getting in and out of a chair without requiring physical assistance.
    b) Mobility – the ability to move from room to room without requiring any physical assistance.
    c) Dressing – putting on and taking off all necessary items of clothing without requiring assistance of another person.
    d) Bathing/Washing – the ability to wash in the bath or shower (including getting in or out of the bath or shower) or wash by other means.
    e) Eating – all tasks of getting food into the body once it has been prepared.
    f) Toileting – the ability to use the toilet.

11. "Critical Illness" shall mean an illness that manifests beyond the Waiting Period following the respective Member's Effective Date or the latest date of any reinstatement, and shall cover the illnesses indicated in the Insurance Schedule which are defined hereunder:

1) Cancer - the occurrence of a histologically confirmed invasive malignant tumor involving the spread of malignant cells. Spread of malignant cells means spread of malignant cells to lymph nodes or distant parts of the body; but this criteria is not required if the cancer is first diagnosed after this Supplementary Contract has been in force for two (2) years from the Effective Date or the latest date of any Reinstatement, whichever is the latest.

   The following are excluded: Tumors treated by endoscopic procedures alone, tumors classified as carcinoma in situ, prostate tumors classified as T1 (TNM classification system), malignant melanomas other than those greater than 1.5 mm in depth, other skin cancers, tumors that are a recurrence or metastases of a tumor that first manifested within the Waiting Period, Kaposi's Sarcoma, other tumors associated with Human Immuno-Deficiency Virus (HIV) infection and tumors that pose no threat to life and for which no treatment is required.

2) Cerebrovascular Stroke - an acute neurological event caused by a cerebral or subarachnoid hemorrhage, cerebral embolism or cerebral thrombosis, where the following conditions are met:

   a) There is an acute onset of objective and ongoing neurological signs that are expected to be permanent, and
   b) Findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques, demonstrate a lesion consistent with the acute hemorrhage, embolism or thrombosis.

   Brain damage due to an accident, infection, vasculitis or an inflammatory disease is excluded.

3) Coronary Artery Bypass Surgery - the actual undergoing of open chest coronary artery bypass grafting surgery to one or more coronary arteries due to disease of those arteries. Angioplasty, stent insertion, laser or other intra-arterial procedures, are excluded.

4) Heart Attack - the first occurrence of an acute myocardial infraction where the following conditions are met:

   a) A history of typical chest pain
   b) The occurrence of typical new acute infarction changes on the electrocardiograph.
   c) Elevation of cardiac Troponin (T or I) to at least 3 times the upper limit of the normal reference range or an elevation in CK MB to at least 200% of the upper limit of the normal reference range.

5) Kidney Failure - the chronic, irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

6) Liver Cirrhosis - end-stage liver disease resulting in cirrhosis and with the following features:

   a) Permanent jaundice,
   b) Ascites, and
   c) Encephalopathy or hepatorenal syndrome

   Liver disease secondary to alcohol or drug misuse is excluded.

7) Vital Organ Transplant - the receipt, or a transplant of:

   a) Human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation, or
   b) One of the following whole human organs: heart, lung, liver, kidney and pancreas as a result of irreversible end-stage failure of the relevant organ.

   Other stem cell transplants and transplants of part of an organ are excluded.

8) Alzheimer's Disease - the certain diagnosis of Alzheimer's Disease or Dementia where there is an associated neurological deficit which is solely responsible for a permanent inability to perform independently at least three (3) of the Activities of Daily Living or requiring the continuous supervision of the Member.

   The coverage for the illness will cease after the age sixty (60) or on the expiry date of the Supplementary Contract, whichever is earlier.

9) Amyotrophic Lateral Sclerosis - the occurrence of Amyotrophic Lateral Sclerosis that results in a permanent neurological deficit.

10) Aplastic Anemia - the occurrence of acquired failure of blood production characterized by total and persistent aplasia of bone marrow.

11) Bacterial Meningitis - refers to bacterial meningitis that causes a permanent neurological deficit that results in the permanent inability to perform at least three (3) of the Activities of Daily Living. Bacterial Meningitis occurring in the presence of Human Immuno-Deficiency Virus (HIV) infection is excluded.

12) Benign Brain Tumor – a benign intracranial tumor where the following conditions are met:

   a) The tumor is life threatening
   b) It has caused damage to the brain
   c) It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit.

   The following are excluded: Cysts, Granulomas, Vascular Malformations, Haematomas, Tumors of the pituitary gland, or spine, Tumors of the acoustic nerve.

13) Cardiomyopathy – the occurrence of a cardiomyopathy where the following conditions are met:

   a) There is persistent impairment of left ventricular function (diastolic or systolic) for at least six (6) months, despite optimal treatment.

b) Physical impairment to the degree of at least class 4 of the New York Heart Association Classification of cardiac impairment.

14) Coma – a coma that persists for at least ninety six (96) hours where all the following conditions are met:

a) There is no response to external stimuli for at least ninety six (96) hours.
b) Life support measures are necessary to sustain life.

There is brain damage that results in a permanent inability to perform at least three (3) of the Activities of Daily Living. The permanence of the brain damage must be assessed no sooner than thirty (30) days from the onset of the coma.

15) Encephalitis - viral encephalitis (meaning viral infection of the brain parenchyma) resulting in a permanent neurological deficit that results in the permanent inability to perform at least three (3) of the Activities of Daily Living. Encephalitis occurring in the presence of Human Immuno-Deficiency Virus (HIV) infection is excluded.

16) Fulminant Viral Hepatitis – the occurrence of sub-massive or massive necrosis of the liver caused by a Hepatitis Virus leading to rapid liver failure. The following criteria must be met:

a) Necrosis involving entire lobules (where available);
b) Rapid decrease in liver size;
c) Rapid deterioration of liver functions tests; and
d) Deepening jaundice.

17) Heart Valve Replacement – the undergoing of medically necessary open-heart surgery to replace or repair a heart valve as a consequence of a heart valve defect. Balloon or catheter techniques are excluded.

18) Loss of Hearing – total, permanent and irreversible loss of hearing in both ears as a result of acute disease or accident. Medical evidence in the form of an audiometry and sound-threshold test must be provided.

19) Loss of limbs – the complete and irrecoverable severance of two (2) or more limbs where severance is above the wrist or ankle joint.

20) Loss of Sight – the total and permanent loss of sight in both eyes.

21) Loss of Speech – total, permanent and irreversible loss of the ability to speak which must be established for a continuous period for twelve (12) months. The Company will require satisfactory proof from an appropriate medical specialist that documents both the cause and permanent nature of the total speech loss. All psychiatric related causes are excluded.

22) Major Burns – third degree burns (full thickness skin destruction) covering at least twenty percent (20%) of the surface of the Member's body

23) Motor Neuron Disease – the occurrence of Motor Neuron Disease that results in a permanent neurological deficit.

24) Multiple Sclerosis – the definite occurrence of Multiple Sclerosis where the following conditions are met:

a) Investigations unequivocally confirm the diagnosis to be multiple sclerosis
b) Multiple neurological deficits have occurred over a period of at least six (6) months
c) There is an associated persistent neurological deficit.

Other causes of neurological damage such as Systemic Lupus Erythematosus (SLE) and Human Immuno-Deficiency Virus (HIV) are excluded.

25) Muscular Dystrophy – the occurrence of a progressive muscular dystrophy where the following conditions are met:

a) The classification is either Duchenne, Becker, Limb girdle, Congenital, Myotonic, Fascioscapulo-humeral, Oculopharygeal muscular dystrophies, and
b) There is a permanent neurological deficit that results in a permanent inability to independently perform at least three (3) of the Activities of Daily Living.

26) Paralysis – the total and permanent loss of the use of both arms, or both legs, or one arm and one leg, through paralysis, except where such Injury is self-inflicted.

27) Parkinson's Disease – the occurrence of Parkinson's Disease where there is an associated neurological deficit that results in the permanent inability to perform independently at least three (3) of the Activities of Daily Living .

The coverage for the illness will cease after the age sixty (60) or on the expiry date of the Supplementary Contract, whichever is earlier.

28) Poliomyelitis – the occurrence of Poliomyelitis where the following conditions are met:

a) Poliovirus is identified as the cause,
b) Paralysis of the limb muscles or respiratory muscles must be present and persist for at least three (3) months.

29) Primary Pulmonary Arterial Hypertension – Primary pulmonary arterial hypertension where all the following conditions are met:

a) There is marked elevation of the pulmonary artery pressure,
b) There is evidence of right ventricular failure.

Pulmonary Hypertension secondary to lung disease and other medical conditions is excluded.

30) Progressive Bulbar Palsy – this means degenerative wasting of the muscles including the bulbar muscles as diagnosed by a consultant neurologist that results in a permanent neurological deficit.

31) Progressive Muscular Atrophy – this means involving the wasting of muscles and increased spasticity as diagnosed by a consultant neurologist that results in a permanent neurological deficit.

32) Severe Brain Damage – an accidental head injury causing brain damage that results in a permanent inability to perform independently at least three (3) of the Activities of Daily Living. Self-inflicted injuries are excluded.

33) Surgery to Aorta – the actual undergoing of medically necessary surgery for a disease of the aorta needing excision and surgical replacement of the diseased aorta with a graft. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

34) Terminal illness – the occurrence of a severe illness that will lead to the death of the Member within twelve (12) months. No benefit will be paid if any effective treatment is available. Terminal Illness due to AIDS is excluded.

35) Total and Permanent Disability – uninterrupted disability for not less than six (6) months which prevents the Member from

a) Engaging in any gainful occupation, employment or business for which he is fitted by education or training, or
b) Performing at least three (3) of the Activities of Daily Living as herein defined under this Supplementary Contract, if the Member is unemployed.

The Total and Permanent Disability must (a) result from injury sustained or sickness contracted during the effectivity of this Supplementary Contract, and (b) start while this Supplementary Contract is in force and before its anniversary nearest the 65th birthday of the Member.

All singular shall include the plural and the plural the singular, the masculine gender shall include the feminine gender and the feminine the masculine except when specifically stated.

Part III – MEMBERSHIP ELIGIBILITY

1. Each Member of the Assured defined under the Policy shall be eligible to apply for insurance under this Supplementary Contract provided that he is not over the age of sixty-fifth (65) and has applied for insurance under the Supplementary Contract and the Policy.

2. Notwithstanding the above, the membership eligibility as referred to in the Policy shall apply to this Supplementary Contract.

Part IV – GENERAL PROVISIONS

Section 1 – Supplementary Contract

This Supplementary Contract becomes effective upon approval of the application of the Member and upon payment of the premium as stated in the Insurance schedule attached hereto. When effective, it forms a part of the Policy and the provisions of the Policy as a rule also apply to it. However, the provisions of the Policy that are inconsistent with the provisions of this Supplementary Contract are applicable only to the life insurance of the Member under the Policy and not this Supplementary Contract.

Section 2 – Termination of Member's Coverage

The Member's coverage under this Supplementary Contract shall automatically end on the earliest of the following dates:

a) upon payment to the Member of the amount shown for this Supplementary Contract in the event of professionally confirmed diagnosis of critical Illness; or

b) if the coverage under this Supplementary Contract has been cancelled on the due date of any premium by giving the Company advance written notice; or

c) at the policy anniversary nearest the Member's sixty-fifth (65) birthday; terminates at age 66.

d) if any premium on this Supplementary Contract is not paid within the grace period; or

e) if the Policy is lapsed, surrendered, or otherwise ended.

Termination of this Supplementary Contract shall not prejudice any claim arising prior to the effective date of termination.

All or any part of any premium we may accept after the termination of this Supplementary Contract or which we could no longer apply because of such termination will be refunded to the Assured, and will not create any liability on the Company unless this Supplementary Contract is reinstated or has in the meantime been reinstated.

Section 3 – Reinstatement

If coverage under this Supplementary Contract terminates by reason of non-payment of premiums, the Member may request for reinstatement and the company will reinstate the Supplementary Contract provided all back premiums are paid with interest at the prevailing policy interest rate of the Company and subject to production of evidence of insurability satisfactory to the Company. Such Reinstatement shall only cover any Critical Illness which commences after the Waiting Period following such reinstatement.

WAITING PERIOD

The Waiting Period for this Supplementary Contract shall be 90 days from the Effective Date or any reinstatement.

INSURANCE SCHEDULE

AMOUNT OF INSURANCE. Each individual shall be insured in accordance with the following:

Classification	Amount of Insurance (Php)
All Eligible Members	**P 1,000,000.00**

EFFECTIVE DATE

This page is made part of the Policy and becomes effective upon the effective date of the policy unless another date is shown here.

GROUP HOSPITAL INCOME BENEFIT

DEFINITIONS

"Confinement" means admission in a hospital for a minimum period of twelve (12) hours upon the recommendation of a Physician. Confinement shall be evidenced by a daily room/room & board charge by the hospital.

"Same Confinement" means that if two (2) or more Confinements are due to the same or related injury or illness, or to any complications arising therefrom, such Confinement shall be regarded as one (1) Confinement if each of them is not separated by more than six (6) months from the paid or payable Confinement which immediately precedes it. This rule shall be observed in determining the limit of the benefits.

"Waiting Period" refers to the length of time after the Effective Date of a Member's coverage or any Reinstatement as stated in this Supplementary Contract, within which no benefits are payable by the Company.

"Covered Illness" means an illness occurring after the Waiting Period. For this purpose, an illness has occurred when it has been investigated, diagnosed or treated or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek diagnosis, care or treatment.

"Injury" means bodily injury which
(a) is sustained while this Supplementary Contract is in force,
(b) is caused solely by external, violent and accidental means and independent of any other cause and,
(c) produces a visible contusion or wound on the exterior of the body except in the case of drowning or of internal injury revealed by an autopsy.

"Covered Injury" means Injury occurring after the Effective Date of this Supplementary Contract or Date of its Last Reinstatement, whichever is later.

"Hospital" means a lawfully operated institution for the care and treatment of injured or ill persons, which provides facilities for diagnosis, major surgery and full time nursing service. "Hospital" does not include any institution or that section of any institution, which is operated as a convalescent or nursing home, rest home for the aged, a place for custodial care, or for any similar purpose.

"Pre-Existing Condition" means any illness or condition occurring six (6) months before the Effective Date of a Member's coverage. For this purpose, an illness or condition has occurred when it has been investigated, diagnosed or treated, or when its signs or symptoms have manifested which would cause an ordinary prudent person to seek diagnosis, care or treatment.

"Physician" means a person legally licensed to practice medicine and/ or surgery other than the member or a member of the insured person's immediate family.

ELIGIBILITY

For Non- Employer- Employee Groups:

(e) Any Person who is a BPI Wealth Builder Fund Investor
(f) Any Person who has reached the minimum investments or fund value of Php 800,000, whichever is higher.
(g) Any person who is aged 18-65 years old, terminates at age 66.
(h) In good standing, good health and actively performing the "daily normal chores of life."

"Daily normal chores of life" shall refer to the performance of daily routine task (such as batching, cooking, walking and etc.) solely independently of others.

BENEFITS

While this Supplementary Contract is in force, the Company shall pay an amount equal to the Daily Hospital Income Benefit, as stated in the Schedule of Benefits, for each day during which the member is confined in a hospital due to a Covered Illness or Injury on the recommendation of a Physician, up to a maximum of three hundred sixty-five (365) days with respect to the Same Confinement.

SPECIAL FLYING COVERAGE

We will pay the applicable benefits if the member suffers an Injury while as a passenger (not as an operator or crew member), boarding or alighting from a certified passenger aircraft provided by a commercial airline on any regular, scheduled or non-scheduled, special or chartered flight, and operated by a properly certified pilot flying between duly established and maintained airports over an established passenger route.

INSURANCE SCHEDULE

AMOUNT OF INSURANCE. Each individual shall be insured in accordance with the following:

Classification	Amount of Insurance (Php)
All Eligible Members	P 500.00

EXCLUSIONS

The company will not pay any benefit under this Supplementary Contract for Illness, Injury, Hospitalization or any charges caused directly or indirectly, wholly or partly: (a) by intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; (b) by war, invasion, act of foreign enemy, acts of terrorism, hostilities or warlike operations (whether war be declared or not), mutiny, riot, civil commotion, strike, civil war, rebellion, revolution, insurrections, conspiracy, military or usurped power, martial law or state of siege, or any of the events or causes which determine the proclamation or maintenance of martial law or state of siege, seizure, quarantine, or nationalization by or under the order of any government or public or local authority; (c) by any weapon or instrument employing atomic fission, thermonuclear fusion or any form of radiation, whether in time of peace or war; (d) by murder, frustrated murder or any attempt thereof; (e) by homicide, frustrated homicide or any attempt thereof, or physical injuries, occasioned by the provocation of the Member; (f) by congenital anomalies and conditions arising therefrom; (g) by pregnancy and resulting childbirth, miscarriage or abortion; (h) by cosmetic or plastic surgery, except as a result of Injury; (i) while the Member is in active service in the Armed Forces of any country or any international authority and in such an event, we, upon written notification by the Assured, shall return the pro-rata premium for any such period of service; (j) while in any attempted commission of, or willful participation by the Member in, any crime punishable under any prevailing law or ordinance of the Philippines or of any country in which the crime was attempted; (k) while resisting lawful arrest; (l) while entering, leaving, operating, servicing, or being in, on, or about any aerial or submarine device or conveyance except as specifically provided herein; (m) by dental care or surgery except to natural teeth as occasioned by Injury; (n) routine health checks, any investigation(s) not directly related to admission diagnosis, illness or injury, or any treatment or investigation which is not medically necessary, or convalescence, custodial or rest care; (o) while under the influence of alcohol or unprescribed drugs; (p) by alcoholism or drug addiction; (q) by disease, bacterial infection or out of or consequent upon or contributed to by Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC); (r) by hernia, ptomaines, or other bacterial infections which are not pyogenic infections occurring at the same time with or because of any accidental cut or wound; (s) by circumcision, sterilization, artificial insemination, sex transformation, diagnosis and treatment of infertility, congenital deformities and defects; (t) by psychosis, mental or nervous disorders, sleep disturbance disorders; (u) by automobile and motorcycle racing, judo, karate and similar martial arts, scuba diving, hang-gliding and sky-diving; (v) by poison, gas or fumes voluntarily or involuntarily taken.

EFFECTIVE DATE

This Supplementary Contract takes effect on the Effective Date as shown on the first page of this contract except for a member who is hospitalized or disabled. The coverage on such member shall take effect thirty-one (31) days after such hospital confinement or disability terminates.

If a Proposed Insured is, on account of injury or disease, not actively a BPI Wealth Builder Fund Investor on the date his insurance would otherwise have become effective as provided by the Supplementary Contract, the Insurance shall not become effective until the date such person returns to as an active BPI Wealth Builder Fund Investor .

WAITING PERIOD

The Waiting Period, if any, for this Supplementary Contract shall be 0 days from the Effective Date of a Member's coverage or the date of a Member's Last Reinstatement, whichever is later.

RENEWAL CONDITIONS

This Supplementary Contract may be renewed for further consecutive periods by the payment of premium on the effective date of the renewal at the Company's premium rate in force at the time of renewal, subject to the Company's right to decline renewal of this Supplementary Contract on any anniversary date of the Supplementary Contract upon giving forty-five (45) days prior written notice mailed or delivered to the Assured at the address shown in the Application of the Company's intention not to renew the Supplementary Contract or to condition its renewal upon reduction of limits, increase in premium, or elimination of coverages and provided that the number of Members is not less than 5.

The Company's acceptance of premium shall constitute its consent to renewal. Unless renewed as herein provided, the Supplementary Contract shall terminate, at the expiration of the grace period for any premium not paid when due.

The Company reserves the right to change, at any time and from time to time, subject to the approval of the Insurance Commission, the table of rates applicable to premiums thereafter becoming due under this Supplementary Contract.

NOTICE OF HOSPITALIZATION

The Company must be given written notice within thirty (30) days after the date of commencement of Confinement in the hospital. Delay in giving the notice, if excusable, will not invalidate the claim.

PROOF OF HOSPITALIZATION

Satisfactory proof of hospitalization must be filed at any of Philamlife's offices within ninety (90) days after the date of being discharged from the hospital together with the hospital's official statement of accounts and receipts. Delay in giving the proof, if excusable, will not invalidate the claim.

In considering a claim under this Supplementary Contract, the Company shall have the right to examine the person suffering the loss when and as often as reasonably required while the claim is in process and during the entire period that the Company is liable to pay the benefit under this Supplementary Contract.

In case of death, the Company shall have the right to require due proof that death occurred according to the terms of this Supplementary Contract and to examine the body of the member and make an autopsy unless forbidden by law.

TO WHOM BENEFITS ARE PAYABLE

Benefits, if any, are payable to the member, if alive, otherwise to the Beneficiary named in the enrollment form provided such Beneficiary is not legally disqualified and survives the member; otherwise, to the person or persons then following the order of preference: the member's

(a) Widow or Widower;
(b) surviving Children;
(c) surviving Parents;
(d) surviving Brothers and Sisters;
(e) His Estate.

Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of the payment.

PAYMENT OF HOSPITALIZATION BENEFITS

All accrued benefits provided under this Supplementary Contract will be paid after the discharge of the member from the Hospital. However, in the event of a Hospital Confinement for a period exceeding ten (10) days, the Company will, at your written request, make periodic payments of such benefits, but not more than three times a month.

COORDINATION OF HOSPITAL INCOME BENEFITS

The total daily hospital income benefit from this Supplementary Contract and other in-force hospital income policies and supplementary contracts issued by this Company shall be subject to a maximum amount of P4,500.00 per covered day of Confinement.

Should the total hospital income benefits payable from this Supplementary Contract and from all in-force hospital income policies and supplementary contracts issued by this Company covering the Member exceed the foregoing applicable limits indicated above, then the hospital income benefit under the last hospital income policy(ies) or supplementary contract(s) which gave rise to the excess shall be correspondingly reduced and all premiums paid on such portion of the hospital income benefit shall be returned to the Assured.

PRE-EXISTING CONDITION LIMITATION

During the first twelve (12) months from the Effective Date of a Member's coverage under this Supplementary Contract, no benefits shall be provided for Hospital Confinement resulting from any Pre-existing Condition or from Injury sustained prior to the Effective Date.

REINSTATEMENT

This Supplementary Contract may be reinstated, if such has lapsed for non-payment of premium, subject to Assured's payment of all back premiums due, including interest, and its compliance of the reinstatement requirements of the Company obtaining at the time of reinstatement.

GROUP TERMINATION

All coverages under this Supplementary Contract shall automatically terminate on the date the Group Master Policy or this Supplementary Contract is terminated.

IMPORTANT NOTICE

The Insurance Commission of the Philippines, with offices in Manila, is the government office in charge of the enforcement of all laws relating to insurance companies. It is ready at all times to render assistance in settling any controversy between Insurance Company and a Policyholder relating to insurance matters.