**REQUEST FOR PRODUCTION, COPYING AND/OR ERASURE OF DATA**

**DECLARATION:**

I declare that the information I will give are true and correct. I hereby release Insular Health Care, Inc. ("InLife Health Care") and its officers, employees and agents from any liability arising from any action taken based on this declaration.

I further declare that I am voluntarily filling out this form as I seek the ☐ production, ☐ copying and/or ☐ erasure of my personal data from InLife Health Care's system.

| _____ | _____ | _____ |
|---|---|---|
| Signature above Printed Name (Thumbmark if unable to sign) | Date (MMM/DD/YYYY) | Time (0000H) |

**TO THE DATA SUBJECT/ REQUESTOR:** Under RA 10173 or the Data Privacy Act of 2012, you are entitled to request for the production, copying and/or erasure of any personal data we hold about you. For this purpose, kindly accomplish this form and send it to our Data Protection Officer, **Atty. Gideon V. Peña**, at 2F Insular Health Care Bldg., 167 Dela Rosa St. cor. Legazpi St., Legazpi Village, 1229 Makati City or via email at dataprivacy@insularhealthcare.com.ph

We will do our best to respond promptly and in any event within one month of the following:

- Our receipt of your written request;
- Our receipt of any further information we may ask you to provide to enable us to comply with your request;
- Our receipt of an advisory opinion from the National Privacy Commission in case there is doubt regarding the propriety of your request, whichever happens to be the latest.

The information you supply on this form will only be used for purposes of identifying the personal data you are requesting to be produced, copied and/or erased, responding to your request, and serving as evidence of your request. You are not obliged to complete this form but doing so will make it easier for us to process your request quickly.

However, to ensure that we are producing and/or erasing data of the right person, we require you to provide us with proof of your identity or of your address. Please supply us with a photocopy or scanned image (do not send the originals) of one or both of the following:

1. Proof of Identity (e.g. Passport, Driver's License, PRC ID, NBI Clearance, Postal ID. Please refer to BSP Circular No. 608, s. 2008 for a complete list of 'Valid Identification Cards for Financial Transactions')
2. Proof of Address (e.g. utility bill, bank statement [no more than 3 months from date of issue]).

If we are not satisfied that you are who you claim to be, we reserve the right to refuse to grant your request.

| | | | |
|---|---|---|---|
| Date today (MMM/DD/YYYY) | | | |
| Name (Last Name, First Name, Middle Name) | | | |
| Address | | | |
| Contact Number | | Email Address | |

**Please check the appropriate box and read the instruction which accompanies it:**

☐ YES, I am the Data Subject. I hereby enclose proof of my identity as stated above.

☐ NO, I am not the Data Subject and I am merely acting on his/her behalf. I have enclosed the Data Subject's written authorization (not applicable for legal guardians of minors) and proof of the Data Subject's identity and my own identity as stated above.

Details of the Data Subject (if Requestor is not the Data Subject):

| | | | |
|---|---|---|---|
| Name (Last Name, First Name, Middle Name) | | | |
| Address | | | |
| Contact Number | | Email Address | |

In order to help us identify the systems that may contain information about you, please check the applicable boxes below that describe the relationship of the Data Subject with InLife Health Care:

☐ HMO Member
☐ Medical Partner/ Provider
☐ Job Applicant
☐ Former Employee or Contractor
☐ Employee or Contractor
☐ Employee's Family Member, Dependent, Beneficiary or Designated Emergency Contact
☐ Employee of InLife Health Care's Supplier or Vendor
☐ Others: _____

Given the sensitive nature of producing, allowing reproduction and/or erasing personal data, certain conditions have to be met before a request may be considered. For this purpose, please check the applicable reason(s) why you wish your data to be produced, copied and/or erased.

☐ I want to transfer HMO coverage to: _____

☐ My personal data is no longer necessary for the purposes for which it was originally collected.

☐ My consent was obtained through ☐ fraud, ☐ accident ☐ mistake or ☐ coercion.

☐ I no longer consent to the processing of my personal data.

☐ I feel that my personal data has been unlawfully or unfairly processed.

☐ I am subject to a legal or contractual obligation that requires the erasure of my personal data from InLife Health Care's system.

☐ I am a minor/ I represent a minor/ I was a minor at the time of the data processing and the continuous data processing is no longer beneficial to me/ the minor I represent

☐ Others: _____

Please describe the information you wish to be produced, copied and/or erased. You can provide any relevant details you think will help us identify the information. You can also attach screenshot images of the said information. Please also explain why the information is about you or the person you are representing on this form. (You may use a separate sheet if necessary)

| |
|---|
| |

Kindly note that in certain circumstances where the erasure of data would adversely affect any person's freedom of speech or expression, contradict a legal obligation, act against public interest in the area of public health or in the area of scientific or historical research, or prohibit the establishment of a legal defense or exercise of other legal claims, we may not be able to erase the information subject of your request. In any of such cases, you will be informed promptly and given full reasons for the decision.

While in most cases we will be happy to produce, allow the copying of and/or erase the data subject of your request, we nevertheless reserve the right to refuse or charge a fee if the request is considered manifestly unfounded or excessive. In case of doubt regarding the propriety of your request, we may seek the opinion of the National Privacy Commission.

For any data privacy concern, please feel free to consult InLife Health Care's Data Protection Officer at dataprivacy@insularhealthcare.com.ph or Tel: 813-0131 loc 8505, or the National Privacy Commission at www.privacy.gov.ph

**ACKNOWLEDGEMENT:** I hereby confirm that I understand the foregoing and that all information I have given are true and correct. I hereby release InLife Health Care and InLife Related Entities from any liability arising from the production and/or erasure of personal data made in accordance with this request.

I understand that any attempt to mislead may result in prosecution.

**[Maaaring tawagin ang pansin ng tauhan ng InLife Health Care kung hindi nakakaunawa ng Ingles. Huwag pumirma kung mayroong hindi naiintindihan.]**

| _____ | _____ | _____ |
|---|---|---|
| Data Subject's Signature above Printed Name<br>(Thumbmark if unable to sign) | Date (MMM/DD/YYYY) | Time (0000H) |

**IF DATA SUBJECT IS A MINOR OR INCAPABLE TO GIVE CONSENT**

| _____ | _____ | _____ |
|---|---|---|
| Signature above Printed Name<br>(Thumbmark if unable to sign) | Relationship to Data Subject | Date (MMM/DD/YYYY) |

Reason why the Data Subject cannot accomplish this form: