Claimant's Statement
(Accidental Dismemberment & Disablement)

In this form, *you* and *your* refer to the life insured and policy owner whose information we are processing or disclosing. ***We, us, our*** and ***the Company*** refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life group of companies.

1 General information

Relating to the Life Insured

Name of Life Insured (Last Name, First Name, Middle Name)			Date of Birth (month/day/year)
Complete Address P.O. Box is not acceptable (No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code)			
Policy Number(s)			
Home Phone	Business Phone	Mobile Phone	E-mail Address
Policy owner, if other than the Life Insured (Last Name, First Name, Middle Name)			

2 Details of the Accident

When did it happen? (Date and Time)	Where did it happen?
How did it happen? (Give full particulars)	
What was the nature of occupation immediately prior to the accident? (Describe the usual and customary duties of your occupation)	

Type of claim

- ☐ Disablement - proceed to the next page
- ☐ Dismemberment - specify loss below

Losses suffered by the life insured		Date of Loss (month/day/year)
☐ sight of one eye	☐ both eyes	____________
☐ hearing of one ear	☐ both ears	____________
☐ one hand	☐ both hands	____________
☐ one arm	☐ both arms	____________
☐ four fingers & thumb of one hand	☐ index finger	____________
☐ four fingers	☐ middle finger	____________
☐ thumb	☐ ring finger	____________
☐ metacarpals of 1st and 2nd (additional)	☐ little finger	____________
☐ metacarpals 3rd, 4th or 5th (additional)		
☐ one foot	☐ both feet	____________
☐ one leg	☐ both legs	____________
☐ all toes on one foot		____________
☐ big toe		____________
☐ any toe, other than big toe, each		____________

2 Details of the Accident (continued)

Names and addresses of all physicians who attended you for the injuries sustained and period of treatment.

Physician's Name & Address	Inclusive date of confinement	Nature of Injuries

Name of regular attending physician during your confinement/treatment.

3 Claimant's Statement

Names and addresses of hospital, clinic or other institution where you had been confined and received treatment.

Name of hospital, clinic or institution	Date of confinement/consultation	Nature of Injuries

Are you still confined by doctor's order? If "Yes", check if confined to:

☐ hospital ☐ home ☐ bed	Since when? (month/day/year) From: | To:	When do you expect to be able to resume work?

Are you covered with similar benefits with any other company? ☐ Yes ☐ No If "Yes", give details:

Name of Insurance Company	Policy Number	Benefit Type

Have you filed claims under these benefits? ☐ Yes ☐ No

Do you smoke cigarettes/cigarillos/cigars or consume any other tobacco product? ☐ Yes ☐ No

a) If "Yes", fill out appropriate box with quantity per day

cigarettes	e-cigarettes	cigars	others, specify:

b) If "No", have you ever smoked a cigarette/cigarillos/cigar or consumed any other tobacco product in the past?

☐ Yes ☐ No

If "Yes", when was the last time you smoked a cigarette/cigarillos/cigar or consumed any other tobacco product? (month/year) _____________

4 Payment Options

Indicate how you would like to receive the benefit proceeds. Kindly choose from the following options:

☐ **Fund Transfer**

☐ Credit to your local bank account with the following information:

Account Name ______________________

Bank Name ______________________

Routing or Serial Number* ______________________

Swift Code Number* ______________________

**not applicable for Peso Account*

☐ Telegraphic Transfer (applicable only to a Claimant residing abroad) Convert to US Dollar/Canadian Dollar/Others - specify currency and credit to bank account through overseas transfer with the following information:

Account Number ______________________

Bank Address ______________________

You agree to shoulder any bank fees and charges arising from the foregoing deposit to your account. The Company will not be liable if the remittance is credited to an erroneous bank account number.

You further agree that the company shall not be responsible nor liable whatsoever for any failure, fault or negligence on the part of the bank to deposit the proceeds to your account.

☐ **Check** (for Peso policy only)

☐ **RCBC** Demand Draft (for US Dollar policy only)

☐ Send through Servicing Advisor at preferred mailing location (automatic if no instruction provided)

☐ For pick-up at Sun Life office (specify the location): ______________________

☐ For Check - Send by courier/registered mail (specify address): ______________________

☐ For RCBC Demand Draft - For encashment (provide details below):

Date of Encashment: ______________________ RCBC Branch Address: ______________________

5 Signatures

By signing, you acknowledge/agree that:

a. To the best of your knowledge and belief that the above answers and those on any attached sheet are complete and true.

b. You authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of you and/or the life insured, or your and/or the life insured's health, to give to the Company any and all information about you and/or the life insured with reference to your and/or the life insured's health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment.

c. You agree that the Company can process your personal data to (i) implement your benefit instructions; (ii) enforce/fulfill contractual rights/obligations; (iii) improve how it develops and provides services (including development of and improvement in its systems and business processes, data analytics, automated processing, artificial intelligence, etc.); (iv) comply with applicable laws or regulations whether domestic or foreign; and (v) manage risks and pursue its legitimate interests.

d. You also agree that (i) the Company may disclose your personal data to its affiliates, service providers, and other third parties for processing consistent with the foregoing purposes, who shall be bound by contractual or other reasonable means to protect your personal data; (ii) that your personal data shall be retained for the duration of the policy/ies listed or existence of the related account(s) and/or upon the expiration of the retention limit set by the Company standards, laws and regulations, counted from account closure; and (iii) you have read, understood, and agree with the declarations and authorizations above, including the Company's privacy policy at https://apps.sunlife.com.ph/privacy.

e. You will indemnify, hold free and harmless the Company, its affiliates, directors, employees, legal representatives, and assignees against loss and damage from any claims and/or actions made by any third person including the parties to the policy or their representatives in relation to the processing of this application form.

f. You agree that the claims application shall not be considered complete until the submission of all the required documents.

Signature of Life Insured, if age is sixteen (16) and over X	Printed Full Name of Life Insured (Last Name, First Name, Middle Name)
Signature of Parent, if Life Insured is under eighteen (18) years of age X	Printed Full Name of Parent (Last Name, First Name, Middle Name)
Place of Signing	Date of Signing (month/day/year)

Signature of Witness X	Printed Full Name (Last Name, First Name, Middle Name)	
Place of Signing	Date of Signing (month/day/year)	
Residence Address (P.O. Box is not acceptable) No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code		
Home Phone	Work Phone	Mobile Phone