Claimant's Statement
(Female and Maternity Benefits)

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 Life Insured information

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)			

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2 Female Benefit Claim Information

This claim is for (Choose from the list of Female Benefits below)

- ☐ Cancer of the
  - ☐ Breast
  - ☐ Cervix Uteri
  - ☐ Uterus
  - ☐ Ovary
  - ☐ Fallopian Tube
  - ☐ Vagina
- ☐ Carcinoma-in-situ of the
  - ☐ Uterine Corpus
  - ☐ Fallopian Tube
  - ☐ Ovary
  - ☐ Vagina
- ☐ Systemic Lupus Erythematosus
- ☐ Rheumatoid Arthritis
- ☐ Severe Osteoporosis
- ☐ Hysterectomy
- ☐ Dilatation and Curettage
- ☐ Major Plastic Surgery Due to Accidental Burning
- ☐ Skin Transplantation Due to Accidental Burning

3 Maternity Benefit Claim Information

This claim is for (Choose from the list of Maternity Benefit below)

- ☐ Pregnancy Complications
  - ☐ Disseminated Intravascular Coagulation (D.I.C.)
  - ☐ Ectopic Pregnancy
  - ☐ Hydatidiform Mole

4 Claim Details

Provide full and exact details of diagnosis	
Date symptoms first occurred (month/day/year)	Date the life insured first consulted a doctor for the condition (month/day/year)
Date the diagnosis of the condition was first made (month/day/year)	Date of surgery, if applicable (month/day/year)
Name of doctor who made the diagnosis	

4 Claim Details (continued)

List name(s) and address(es) of physician(s) consulted or hospital(s) where confined for the condition.

Names of Physician and/or Hospital	Address	Date of Consultation/ Period of Confinement

Give the name and address of the life insured's usual medical attendant if different from above.

What kind of treatment has the life insured received in relation to the condition?

Has the life insured previously suffered from or received treatment for a similar or related condition? ☐ Yes ☐ No If "Yes", give details:

Names of Physicians/Hospitals	Addresses	Date (month/day/year)	Reason

Has the life insured previously suffered from any other illness or condition? ☐ Yes ☐ No If "Yes", give details:

Diagnosis	Date when first diagnosed (month/day/year)	Name of attending doctor

Is the life insured covered for similar benefits with any other company? ☐ Yes ☐ No If "Yes", give details:

Name of Insurance Company	Policy Number	Issue Date (month/day/year)	Amount of Benefit

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) ____________

5 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: ______________________

6 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 X	Printed Full Name of Life Insured (Last Name, First Name, Middle Name)
Signature of Policy Owner, if other than the Life Insured 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