Claimant's Statement (Disability)

Sun Life

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.

This claim is for:
(Check appropriate box)

- ☐ Total Disability Benefit on the life insured
- ☐ Premium Coverage Upon Death or During Total Disability of Initial Owner

1 General information

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

2 Claimant's Statement

What was your occupation on date of onset of your present disability? (Check appropriate boxes and provide details if necessary on the blanks provided.)

☐ Employee
- ☐ Clerical/Rank & File — Position Title _____
- ☐ Technical — Position Title _____
- ☐ Supervisory — Position Title _____
- ☐ Middle Management — Position Title _____
- ☐ Senior Management — Position Title _____
- * Office Address _____

☐ Businessman
- ☐ Nature of Business _____
- * Business Address _____

☐ Professional
- ☐ Doctor of Medicine
- ☐ Dentist
- ☐ Nurse/Therapist
- ☐ Lawyer
- ☐ Engineer/Architect
- ☐ Teacher/Professor
- ☐ Others, specify _____
- * Office Address _____

☐ Housewife
☐ Student — Name of School _____
☐ Others — Specify _____

Immediately prior to onset of disability, what were the activities related to your work or routine functions? Check appropriate boxes.

☐ Sitting	☐ Travel (land)	☐ Lifting Heavy Objects	☐ Cashiering
☐ Prolonged Standing	☐ Travel (air)	☐ Assembly Line Work (using hands/feet)	☐ Attending To Telephone Calls
☐ Frequent Walking	☐ Travel (sea)	☐ Furniture/Equipment Repair	☐ Attending To Customers (personal)
☐ Frequent Climbing	☐ Household Chores	☐ Routine Clerical Paper Work	☐ Attend & Conduct Meetings/Seminars
☐ Driving	☐ Gardening	☐ Computer Work	☐ Analysis, Judgement & Decision Making
☐ Supervision & Management	☐ Sales & Marketing (client calls)	☐ Others, specify _____	

When did you last work? (month/day/year)	When did the symptoms first occur? (month/day/year)
What is the cause of your present disability?	What were earliest symptoms of your disability?

2 Claimant's Statement (continued)

What is your present state of health? Describe how your condition prevents you from working. (If life insured is not working, describe how your condition prevents you from performing your usual activities.)

Has such disability existed continuously to present date? ☐ Yes ☐ No If "No", give particulars:

Are you presently confined in a hospital, at home or in bed? ☐ Yes ☐ No If "Yes", give particulars:

Date your physician first treated you for your present disability. (month/day/year)	Date you expect to be able to return to work, either full or part time. (month/day/year)

List names and addresses of all physicians consulted during your present illness.

What were the medications your physicians prescribed?	What were the treatment/operations done?

What injuries or illnesses have you had prior to your disability?

What insurances (including those with the Company) do you have with provision for disability benefits? Indicate the name of the company, policy number and benefit type.

Name of the Company: _____

Policy Number : _____

Benefit Type : _____

_____

Indicate your level of education, including degrees attained, vocational or technical courses taken and occupation for which you are skilled.

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) _____

3 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: _____

4 Signature

This section must be signed by the life insured and the policy owner, if he/she is not also the person insured.
If claim is for Premium Coverage Upon Death or During Total Disability of Initial Owner, only the policy owner must sign in the space provided for.

By signing, you acknowledge/agree that:

a. The answers and declarations made on this application are complete and true. You agree and understand that any concealment or misrepresentation made herein may be a ground for rescission of the insurance coverage and denial of future claims. You also consent to a personal investigation on you and a copy of the authorization granted in this form shall be as valid as the original.

b. 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.

c. You also agree: (i) that 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 account(s) listed or existence of the related account(s) and/or upon the expiration of the retention limit set by Company standards, laws and regulations, counted from account closure; and (iii) with the Company's privacy policy at https://apps.sunlife.com.ph/privacy.

Signature of Life Insured X	Full Name of Life Insured
Signature of Policy Owner X	Full Name of Policy Owner
Place of Signing	Date of Signing (month/day/year)