Attending Physician's Statement (SUN Fit and Well)

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 Financial group of companies.

PRINT clearly. Use BLACK ink. Indicate N/A if question is not applicable. If with erasures, please countersign.

1 Life Insured

Policy Number/s	
Name (Last, First, M.I.)	Date of Birth (month/day/year)
Residence Address	
Contact Number/s	E-mail Address
Policyowner (last name, first name, M.I.) - Please complete if policyowner is other than the life insured	

Data Privacy and Authorization

Medical Information Database

In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph

Authorization to Process Your Personal Data

You understand and acknowledge that the Company, its employees, duly authorized representatives, related companies, third party service providers and vendors, shall use, process and share your information, including sensitive personal information, with any person or organization to (i) administer and service this insurance or investment account; (ii) process claims and enforce/fulfill contractual rights/obligations; or (iii) for other reasonable purposes related to the provision of products and services (including but not limited to improvement/upgrade in systems and business processes, data analytics, automated processing, etc.).

The Company may further process your information for purposes of complying with its legal obligations, laws and regulations (including but not limited to the Anti Money Laundering Act and Credit Information Systems Act); pursue its legitimate and lawful rights and interests; and other purposes allowed under privacy laws and regulations.

Your rights include the right to be informed, access your data, and rectify errors in your data. For more information about your rights and how we protect your data, you may access our privacy policy at https://online.sunlife.com.ph/privacy. Should you have any concerns in relation to your rights or the processing of your personal and sensitive personal information, you may get in touch with our Data Protection Officer at privacyconcern@sunlife.com.

Your personal data shall be retained throughout the duration of your coverage under your plan or existence of your account(s) and/or until expiration of the retention limit set by laws and regulations from account closure and the period set for destruction or disposal of records. You certify that you have read, understood and agree with the declarations and authorizations above, including Sun Life's privacy policy found in https://online.sunlife.com.ph/privacy.

Would you like to receive personalized communications, products, and service offers from the Company, Sun Life Asset Management Company, Inc. (SLAMCI) and related parties that may help with your financial needs? ☐Yes ☐No

Signature of Patient (or Parent, if minor)	Printed Name of Patient/ Parent X
Date of Signing (month/day/year)	Place of Signing

2 Physician's Statement

This claim is for: (Please choose from the list of benefits below)

Group	Minor Critical Illness	Major Critical Illness
Heart Related	☐ Cardiac Defibrillator ☐ Cardiac Pacemaker Insertion ☐ Angioplasty and other Invasive Treatment for Coronary Artery Disease ☐ first Angioplasty ☐ with previous Angioplasty *Please specify the date (month/day/year)* _____	☐ Acute Heart Attack ☐ Coronary Artery Bypass Surgery ☐ Dissecting Aortic Aneurysm ☐ Replacement of Heart Valve ☐ Surgery for Disease of the Aorta (Aorta Surgery) ☐ Cardiomyopathy ☐ Eisenmenger's Syndrome ☐ Idiopathic Pulmonary Arterial Hypertension ☐ Severe Infective Endocarditis
Cancer Related	☐ Carcinoma-in-situ of the following sites: breast, uterus,fallopian tube, vulva, vagina, cervix uteri, colon, rectum, penis, testis, lung, stomach, or nasopharynx ☐ Early Prostate Cancer ☐ Early Thyroid Cancer ☐ Early Bladder Cancer ☐ Early Ovarian Cancer ☐ Early Chronic Lymphocytic	☐ Invasive Cancer ☐ Cerebral Metastasis
Liver Related		☐ End Stage Liver Failure ☐ Fulminant Hepatitis
Kidney Related	☐ Surgical Removal of One Kidney ☐ Chronic Kidney Disease	☐ Medullary Cystic Disease ☐ End Stage Renal Disease ☐ Systemic Lupus Erythematosus (S.L.E.) with Lupus Nephritis
Lung Related	☐ Insertion of a Vena-Caval Filter	☐ End Stage Lung Disease
Neurological Related	☐ Cerebral Shunt Insertion ☐ Cerebral Aneurysm Surgery ☐ Moderately Severe Alzheimer's Disease ☐ Moderately Severe Parkinson's Disease	☐ Stroke ☐ Alzheimer's Disease ☐ Parkinson's Disease ☐ Amyotrophic Lateral Sclerosis (ALS) ☐ Progressive Bulbar Palsy (PBP) ☐ Progressive Muscular Atrophy (PMA) ☐ Progressive Supranuclear Palsy ☐ Guillain-Barre Syndrome ☐ Motor Neuron Disease (MND) ☐ Multiple Sclerosis ☐ Bacterial Meningitis ☐ Benign Brain Tumor ☐ Coma ☐ Major Head Trauma ☐ Brain Surgery ☐ Meningeal Tuberculosis ☐ Encephalitis ☐ Apallic Syndrome ☐ Muscular Dystrophy ☐ Creutzfeldt-Jacob Disease ☐ Severe Myasthenia Gravis ☐ Paralysis ☐ Hemiplegia
Gastrointestinal Related		☐ Severe Crohn's ☐ Severe Ulcerative Colitis ☐ Acute Necrohemmorhagic Pancreatitis ☐ Chronic Relapsing Pancreatitis
Blood Related		☐ Aplastic Anaemia ☐ Occupational Acquired HIV
Others		☐ Deafness ☐ Loss of Limbs ☐ Total Blindness ☐ Loss of Speech ☐ Major Burns ☐ Major Organ Transplant ☐ Terminal Illness ☐ Amputation due to Diabetic Complication ☐ Elephantiasis ☐ Poliomyelitis ☐ Severe Rheumatoid Arthritis ☐ Ebola ☐ Surgery for Idiopathic Scoliosis

2 Physician's Statement (continued)

Others		☐ Necrotizing Fasciitis ☐ Loss of Independent Existence ☐ Chronic Adrenal Sufficiency ☐ Progressive Scleroderma ☐ Pheochromocytoma
Child Conditions	☐ Dengue Hemorrhagic Fever (Grades III and IV) ☐ Hemophilia A and Hemophilia B ☐ Insulin Dependent Diabetes Mellitus ☐ Kawasaki Disease ☐ Osteogenesis Imperfecta ☐ Rheumatic Fever with Valvular Impairment	

Date when you first attended the patient for the disease (month/day/year)	How long do you believe the symptoms had been present when you were first consulted?
Date the patient was informed of the diagnosis (month/day/year)	Date of surgery, if applicable (month/day/year)

Dates of Hospital Confinement:

Date of Admission (month/day/year)	Date of Discharge (month/day/year)
Name and Address of Hospital	Telephone Number(s)

Provide full and exact details of diagnosis. Please specify the stage or classification in the box provided below.

Please describe the underlying cause of the patient's condition. And if surgery was done, please provide the reason in the box provided below.

Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests.Please include dates.

Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", state when. (month/day/year) _____
Describe condition.

What kind of treatments has the insured received in relation to the condition? Please provide the answer in the box provided below.

Can the patient's condition still be resolved by medication/treatment/surgery? ☐ Yes ☐ No Please explain in the box provided below.

Were there other treatments/procedures recommended to the insured? If "Yes", please specify in the box provided below. ☐ Yes ☐ No

Did the patient's condition result in any major, permanent neurological deficit that will require physical rehabilitation? ☐ Yes ☐ No

Since when (month/day/year)	Expected Recovery (month/day/year)

2 Physician's Statement (continued)

Is the patient capable of performing activities of daily living? ☐ Yes ☐ No

If no, what activities of daily living is the patient unable to perform?

Activities of Daily Living	Since when (month/ day/ year)	Expected Recovery (month/ day/ year)
washing/ bathing		
dressing		
transferring		
toileting/ using the lavatory		
feeding		
mobility		

If yes, did the patient experience inability to perform the activities of daily living?

☐ No

☐ Yes. Please answer the table below

Activities of Daily Living	Start date (month/ day/ year)	Recovery date (month/ day/ year)
washing/ bathing		
dressing		
transferring		
toileting/ using the lavatory		
feeding		
mobility		

Prognosis	Present Condition	Predicted Survival Period from date of diagnosis (Life Expectancy)

Has the patient patient been hospitalized or attended to for any other medical condition? ☐ Yes ☐ No Please provide details.

Name and Addresses ofAttending Physician	Date of Consultation	Diagnosis

Are you the patient's regular attending physician? ☐ Yes ☐ No Please provide details.

Period of Consultation	Past Health History

2 Physician's Statement (continued)

Please provide details of physicians to whom the patient had been referred, or who attended the patient.

For Deafness, Total Blindness and Loss of Speech: Is the condition total and irrecoverable? ☐ Yes ☐ No

If "No", please provide details on the box provided below.

Does the patient 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

b. If "No", has the patient ever smoked a cigarette/cigarillo/cigar or consumed any other tobacco product in the past? ☐Yes ☐No

If "Yes", when was the last time the patient smoked a cigarette/cigarillo/cigar or consumed any other tobacco product? month/year

If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.

3 Signature

Signature ofAttending Physician X		Printed Name
PTR No.	License No.	Field of Specialization

Medical Office Address		
Contact Number/s	E-mail Address	
Clinic Hours	Date of Signing (month/ day/ year)	Place of Signing