Hospital Income Benefit (HIB) Claim Form

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 Sun Life group of Companies.

As your partner for life, we know that your health is your foremost priority during these times and we would like to help you focus on your recovery by expediting the processing of your claim. Please take note of the following reminders so we can process your claim swiftly.

- Accomplish and submit the completed form and all applicable claim requirements (see pages 3 and 4) through any of our Client Service Centers or email to phil_claims@sunlife.com. Incomplete information and/or documents will affect the processing of your claim.
- Write legibly using capital letters. Write N/A if question is not applicable.
- Mark the box(es) with a "✓" to indicate your choice(es) then sign the form only when completely filled out.
- Refrain from using third parties to process your claims.

Fraud Warning
P.D. No. 612 or The Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both to any person who makes any fraudulent claim, or fraudulently prepares claim requirements. '

1 Information about the Life Insured

Name of Life Insured (Last Name, First Name, M.I.)	Policy Number(s)	Date of Birth (Month/Day/Year)
Complete Residence Address (P.O. Box is not acceptable)	Contact Number(s)	E-mail Address

2 Life Insured's Declaration

Diagnosis
Why did the doctor recommend confinement (e.g. symptoms or complaints prior admission)?
Details of the physician for the confinement Name: _____ Clinic/hospital address: _____ Contact number: _____ Email address: _____

Did you consult other physicians for this condition prior to this confinement? ☐ Yes ☐ No

If "Yes," please provide the details below:

Name of Physician	Contact Number(s)	E-mail address

Date of Consultation (Month/Day/Year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/Remarks	Hospital	Medication Prescribed/ Treatment

If the space is insufficient, use the back page of this form

During the confinement, were there other physicians who gave treatment? ☐ Yes ☐ No If "Yes," please provide the details below:

Name of the Physician	Field of Specialization

If the space is insufficient, use the back page of this form

Did you suffer from any other illness, disease, or condition? ☐ Yes ☐ No If "Yes," please provide the details below:

Date of Consultation (Month/Day/Year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/Remarks	Hospital	Medication Prescribed/ Treatment

If the space is insufficient, use the back page of this form.

Smoking Habit

Have you ever smoked? ☐Yes ☐No If "Yes," please provide details below:

Start date (Month/Day/Year): _____ End date (Month/Day/Year): _____ ☐ Still in the habit

3 Payment Options

Indicate how you would like to receive the benefit proceeds.

☐ **Credit to account**

☐ Credit to local bank account

☐ Currency conversion (applicable only to a beneficiary residing abroad) – convert to:

☐ US Dollar ☐ Canadian Dollar ☐ Other Currency (please specify) _____

subject to availability of the currency in the bank and credit to bank account through overseas transfer

Account Name:	Bank Address:
Account Number:	Routing or Serial Number *:
Bank Name:	Swift Code Number *:

* applicable only to currency conversion

Important reminders:

1. Please ensure that you provide the correct account information. The Company will not be liable if the remittance is credited to the wrong bank account number.
2. You confirm and agree that:
   b. You will shoulder all bank fees and charges related to the deposit to your bank account;
   c. Deposit of the amount through your designated bank account number or account name fully releases and discharges the Company from any claims or liabilities related thereto; and
   d. You agree to indemnify and hold the Company free and harmless from and against any and all claims, losses, including opportunity loss, damages, or expenses as a result of your credit to account and/or currency conversion request, including any misrepresentation as to the owner of the bank account, and/or failure of your bank or its intermediary to honor the transaction.

☐ **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 location): _____

☐ For Check – Send by courier/registered mail (specify address): _____

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

Date of Encashment (Month/Day/Year): _____ RCBC Branch Address: _____

4 Signatures

By signing, you acknowledged/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 to the processing of your personal and sensitive information for the additional purposes of evaluating your claim and implementing your request/instructions herein in accordance with Sun Life's Privacy Policy available at https://online.sunlife.com.ph/privacy, reaffirm your consent to the processing of your personal data as recorded in your most recent insurance application form, and acknowledge that such consent continues to be in full force and effect.

d. 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.

e. 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 (Last Name, First Name, Middle Name)
Signature of Guardian, if applicable (e.g. Life Insured is a minor or has mental disabilities) X	Printed Full Name (Last Name, First Name, Middle Name)
Signature of Policy Owner, if other than the Life Insured X	Printed Full Name (Last Name, First Name, Middle Name)
Place Signed	Date Signed (Month/Day/Year)

CHECKLIST OF REQUIREMENTS

IMPORTANT REMINDERS

- Submit certified true copies only.
  - Photocopies, except for IDs, are not acceptable.
  - Photocopies of IDs may be submitted provided the original copies are presented for verification.
- Documents submitted to Sun Life of Canada (Philippines), Inc. (SLOCPI) will not be returned.
- We may ask for additional documents after reviewing the requirements you submitted.
- Hospital confinement that occurs within two (2) years from date of policy issue or last reinstatement is subject to investigation and will affect processing time.

A Basic Requirements

☐ **Hospital Income Benefit (HIB) Claim Form** [form provided by SLOCPI]	☐ **Attending Physician's Statement** [form provided by SLOCPI]
☐ **One (1) valid government-issued ID** with photo and signature of the claimant	☐ **Statement of Account from the hospital**

B Conditional Requirements (Submit appropriate requirements as indicated below.)

B.1 Based on Diagnosis

If diagnosis is Heart Attack / Acute Heart Attack (*must be confirmed by a Cardiologist or Cardiovascular Surgeon*) ☐ New electrocardiographic changes (*e.g. ECG report and tracings*) ☐ Blood Test (*e.g. Troponin or CK-MB*)	If diagnosis is Multiple Sclerosis (*must be confirmed by a Neurologist*) ☐ Nerve Biopsy / Neural Biopsy / Electrophysiology Report (*submit only one*) ☐ Medical Records indicating the following: ☐ Two (2) episodes of well-defined neurological abnormalities ☐ Evidence of demyelinating lesions at more than one (1) site within the central nervous system
If diagnosis is Poliomyelitis (*must be confirmed by a Neurologist and/or Infectious Disease Specialist*) ☐ Culture of throat washings, stools or spinal fluid ☐ Spinal tap and examination of the spinal fluid using PCR ☐ Test for levels of antibodies to the polio virus	If diagnosis is Kidney Failure / End-Stage Renal Disease (*must be confirmed by a Nephrologist*) ☐ Creatinine Clearance ☐ Glomerular Filtration Rate (GFR) ☐ Renal Ultrasound Report
If diagnosis is Dissecting Aortic Aneurysm (*must be confirmed by a Cardiologist or Cardiovascular Surgeon*) ☐ CT Scan / MRI / MRA / Angiogram Report (*submit only one*)	If diagnosis is End-Stage Lung Disease (*must be confirmed by a Pulmonologist*) ☐ FEV1 Test Result
If diagnosis is Cancer / Invasive Cancer ☐ Surgical Pathology / Histopathology Report (*submit only one*)	If diagnosis is Stroke (*must be confirmed by a Neurologist*) ☐ CT Scan / MRI Report (*submit only one*)
If diagnosis is Progressive Muscular Atrophy (*must be confirmed by a Neurologist*) ☐ Electromyography Report	If diagnosis is Chronic Liver Disease ☐ Liver Function Test ☐ Ultrasound / CT Scan / MRI Report (*submit only one*)

B.2 Based on Circumstances of Hospital Confinement

If hospital confinement is due to an accident or violent incident ☐ Police Report ☐ Hospital Records of the life insured (*Admitting History and Discharge Summary or their equivalent*) ☐ Driver's License if accident occurred while insured was driving a vehicle ☐ Authorization to Investigate [form provided by SLOCPI]	If hospital confinement occurred within two (2) years from date of policy issue or last reinstatement ☐ Authorization to Investigate [form provided by SLOCPI] ☐ Hospital Records of the life insured (*Admitting History and Discharge Summary or their equivalent*)

B.3 Based on Surgical Operation Performed

If the life insured underwent Major Organ Transplant, or if the plan is Sun First Aid / Sun First Aid Plus and surgical operation was performed

☐ Record of Operation

B.4 Based on Preferred Payment Option

If the claimant prefers to receive the benefit through credit to account

☐ **Proof of bank account** e.g. Bank Statement of Account, Certificate of Bank Deposit, First Page of the Bank Passbook, Check, ATM Card or Validated Deposit/Withdrawal Slip showing the bank account number and account name of the claimant ***(submit only one)***

Special instruction: *The bank account number and the account name must appear on the same page and should be readable and clear. Please mask account details and names of other account holders, if any. The Company may require presentation of additional documents to validate submissions.*

For inquiries and concerns, please contact or visit us at any of the following:

SUNLINK Client Care: (+632) 8849-9888 – Calls outside the Philippines may incur additional charges
Toll-free (using PLDT Line): 1-800-10-SUNLIFE (7865433) outside Metro Manila
8:00 AM to 5:00 PM | Mondays to Fridays

sunlink@sunlife.com

www.sunlife.com.ph

Client Service Center