

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 Financial group of companies.

This claim is for: (Please check appropriate box)

<input type="checkbox"/> Accidental Dismemberment & Disablement (ADD&D)	<input type="checkbox"/> Basic Accident Rider (BAR)
<input type="checkbox"/> Accidental Dismemberment Benefit (AX)	<input type="checkbox"/> Comprehensive Accident Rider (CAR)
<input type="checkbox"/> Accidental Indemnity Benefit (AI)	

1 General Information

Relating to the Life Insured

Life Insured (Last Name, First Name, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)
Complete Address			Policy Number(s)
Policy Number(s)			
Home Phone	Business Phone	Cellphone	E-mail Address
Policy Owner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month/Day/Year)

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	
<input type="checkbox"/> Disablement/Disability - proceed to the next page <input type="checkbox"/> Dismemberment - specify loss below	
Losses suffered by the Life Insured	Date of Loss (month/day/year)
<input type="checkbox"/> sight of one eye <input type="checkbox"/> hearing of one ear	<input type="checkbox"/> both eyes _____ <input type="checkbox"/> both ears _____
<input type="checkbox"/> one hand <input type="checkbox"/> one arm <input type="checkbox"/> four fingers & thumb of one hand <input type="checkbox"/> four fingers <input type="checkbox"/> thumb <input type="checkbox"/> metacarpals of 1st and 2nd (additional) <input type="checkbox"/> metacarpals 3rd, 4th or 5th (additional)	<input type="checkbox"/> both hands _____ <input type="checkbox"/> both arms _____ <input type="checkbox"/> index finger _____ <input type="checkbox"/> middle finger _____ <input type="checkbox"/> ring finger _____ <input type="checkbox"/> little finger _____
<input type="checkbox"/> one foot <input type="checkbox"/> one leg <input type="checkbox"/> all toes on one foot <input type="checkbox"/> big toe <input type="checkbox"/> any toe, other than big toe, each	<input type="checkbox"/> both feet _____ <input type="checkbox"/> both legs _____ _____ _____



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.

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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:

<input type="checkbox"/> hospital <input type="checkbox"/> home <input type="checkbox"/> bed	Since when? (month/day/year) From: _____ To: _____	When do you expect to be able to resume work?
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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

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

4 Payment Options

Indicate how you would like to receive the death 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. 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 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://online.sunlife.com.ph/privacy>.
- 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