Claimant's Statement
(Disability)

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 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)

☐ Disability of the Life Insured
☐ Disability of the Policy 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' Statement

What was your occupation on date of onset of your present disability? (*Please 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
- ☐ Nurse/Therapist
- ☐ Engineer/Architect
- ☐ Dentist
- ☐ Lawyer
- ☐ 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?
Please check appropriate boxes.

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

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 the earliest symptoms of your disability?

2 Claimant' Statement (continued)

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

Has such disability existed continously to present date? ☐ Yes ☐ No If "NO", please 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?	Date you expect to be able to return to work, either full or part time

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 : ______________________________

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

Did 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	other, specify

b) If "No", have you ever smoked a cigarette/cigarillo/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 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: ______________________

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 Disability of the Policy 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://online.sunlife.com.ph/privacy.

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.

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)