Sun Life GREPA Financial

# Claimant's Statement (Disability)

Please **PRINT** clearly.

In this form, "*you*" and "*your*" refer to the life insured and policyowner whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco Group of companies.

This claim is for: (Please check appropriate box)
- ☐ Disability of the Insured
- ☐ Disability of the Owner

## 1 General Information

| | | | |
|---|---|---|---|
| Life Insured (Last Name, First Name, M.I.) ☐ Male ☐ Female | | | Date of Birth (Month/Day/Year) |
| Complete Address | | | Policy Number(s) |
| Home Phone | Business Phone | Cellphone | E-mail Address |
| Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured) | | | Date of Birth (Month/Day/Year) |

## 2 Claimant's 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)

What is the cause of your present disability?

What were the earliest symptoms of your disability?

When did the symptoms firstoccur? (Month/Day/Year)

## 2 Claimant's 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 continuously 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 dates

| 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

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 number per day

| cigarettes | cigars | tobacco | chewing tobacco | other tobacco used |
|---|---|---|---|---|
| | | | | |

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/cigarillo/cigar or consumed any other tobacco product?

month/year

## 3 Signature

This section must be signed by the life insured and the policyowner, if he/she is not also the person insured.

If claim is for Premium Coverage During Total Disability of Initial Owner, only the policyowner must sign in the space provided for.

By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs.

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.

If you need more information about our privacy policy, please visit https://www.sunlifegrepa.com/LegalPrivacySecurity.aspx.

| Signature of Life Insured<br>X | Printed Name |
|---|---|
| Signature of Policyowner<br>X | Printed Name |
| Place of Signing | Date of Signing (Month/Day/Year) |

## 2 Claimant's 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 continuously 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 dates

| 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?

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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 number per day

| cigarettes | cigars | tobacco | chewing tobacco | other tobacco used |
|---|---|---|---|---|
| | | | | |

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/cigarillo/cigar or consumed any other tobacco product?

month/year

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By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs.

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.

If you need more information about our privacy policy, please visit https://www.sunlifegrepa.com/LegalPrivacySecurity.aspx.

| Signature of Life Insured<br>X | Printed Name |
|---|---|
| Signature of Policyowner<br>X | Printed Name |
| Place of Signing | Date of Signing (Month/Day/Year) |