Sun Life GREPA Financial

Claimant's Statement (Hospitalization Benefit)

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):

- ☐ Hospital Income Benefit (HIB)
- ☐ Hospital Surgical Benefit (HSB)
- ☐ Intensive Care Unit Benefit (ICU)
- ☐ Group Life
- ☐ Individual Life
- ☐ Daily Hospital Income Benefit (DHI)
- ☐ Health Plan (HP)

1 General Information

Relating to the person insured

Name (Last Name, First Name, M.I.) ☐ Male ☐ Female			Date of Birth (day/month/year)
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)
Cell Phone Number	Business Phone Number	E-mail Address	Policy Number(s)
Policyowner (lastname, firstname, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (day/month/year)

2 Life Insured's Declaration

1. Reason for Confinement: ☐ Illness ☐ Accident ☐ Maternity/Obstetrical (for HP rider only)
2. What physical conditions/symptoms/complaints led you to seek hospital confinement?

3. Was the confinement at your request? ☐ Yes ☐ No If No, who recommended the confinement?

4. If due to accident, please provide details of the accident.

Date (day/month/year) and time of accident	Where did the accident happen?
Describe how the accident happened.	

5. Were there witnesses to the accident? ☐ Yes ☐ No If yes, please give name(s) and address(es) of one or two witnesses.

Name of Witness			
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)

Name of Witness			
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)

3 Details of Treatment

1. Date physician was first seen for this condition: (day/month/year)

2. Give the name and address of physician first seen for this condition.

Name			
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Telephone Number(s)

3. Give the name and address of hospital where you were confined.

Name			
Address (number, street, municipality			City
Province	Country	Zip Code	Telephone Number(s)

Confined from: Date (day/month/year) and Time Admitted	Through: Date (day/month/year) and Time Discharged

4. Give the name and address of the physician who recommended this confinement/hospitalization.

Name (last, first, M.I.)			
Address (number, street, municipality			City
Province	Country	Zip Code	Telephone Number(s)

5. Give the names and addresses of physicians who treated you at the hospital:

Name and address of Doctor	Field of Specialization

6. Who of the above-named doctors was your regular attending physician during your confinement/ hospitalization:

7. Were you confined in the Intensive Care Unit? ☐ Yes ☐ No
If yes, state inclusive dates of I.C.U. confinement.

From (day/month/year)	To (day/month/year)	Name of hospital

8. Name of physician who advised confinement in the I.C.U.

9. 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 used	cigars	tobacco	chewing tobacco	other tobacco

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

4 Additional Information

1. If confinement is due to illness, have you seen a physician for this condition or a similar/related condition in the past? ☐ Yes ☐ No
   If yes, please give name(s) and address(es) of physician(s) consulted:

Name and address of Doctor	Approximate Dates of Consultation (day/month/year)

2. Have you sought medical advice/been treated/taken medication and/or been hospitalized for the same or similar/related illness/condition in the past? ☐ Yes ☐ No

Name of Doctor	Approximate Dates of Consultations	Medications Prescribed/Taken
Name of Hospital	**Approximate Dates of Confinements**	**Name of Attending Physician**

3. Do you have other existing hospital insurance? ☐ Yes ☐ No If yes, please give name of insurer(s):

4. Do you have other life insurance with hospitalization benefits? ☐ Yes ☐ No
   If yes, please give name of insurer(s):

5. Have you filed claims under these hospitalization insurance? ☐ Yes ☐ No
   If yes, as of this date, have these been settled? ☐ Yes ☐ No

5 Signatures

This section must be signed by the person insured, the parent if applicable, and the policyowner if he or she is not the person insured.

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.

Place of Signing	Date of Signing (day/month/year)
Signature of Life Insured, if age is 16 and over X	Signature of policyowner (if not also the life insured) X
Signature of Parent, if life insured is below 18 years of age X	Printed Name

Signature of Witness X	Printed Name	
Address		Telephone No.
Place of Signing	Date (day/month/year)	