

Attending Physician's Statement (For Covered Critical Illness)

In this form, "you" and "your" refer to the policyowner, life insured, patient and the physician 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.

The patient is responsible for the completion of this form without expense to Sun Life Grepa Financial, Inc.

This form is applicable for Critical Illness Acceleration Benefit, Critical Illness Additional Benefit, Critical Illness Benefit and AEGIS (Term with Dread Disease). Please PRINT Clearly.

1 Life Insured / Patient Information (To be completed by the patient)

Name (Last Name, First Name, M.I.)			Date of Birth (day/month/year)	
Residence Address (no., street, municipality)			City	
Province	Country	Zip Code	Telephone Number(s)	
Cell Phone Number	Business Phone Number	E-mail Address	Policy Number(s)	
Policyowner (Last Name, First Name, M.I.) Please complete if policyowner is other than the life insured				

Authorization:

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.

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

Signature of Patient (or Parent, if minor)	Printed Name of Patient/Parent	Date of Signing (day/month/year)
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2 Physician's Statement (To be completed by the Attending Physician)

Date you first attended the patient for the disease (day/month/year)	How long do you believe the symptoms had been present when you were first consulted?
Date the patient was informed of the diagnosis (day/month/year)	

1. Provide full and exact details of diagnosis.

2. Please describe the underlying cause of the patient's condition.

3. Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, ECG, MRI or any other special tests. Please include dates.)



2 Physician's Statement (To be completed by the Attending Physician) - continued

4. Is the patient capable of performing activities of daily living? Yes No

If no, what activities of daily living is the patient unable to perform?

Activities of Daily Living	Since when? (day/month/year)	Expected Recovery (day/month/year)
<input type="checkbox"/> Bathing		
<input type="checkbox"/> Dressing		
<input type="checkbox"/> Personal Hygiene		
<input type="checkbox"/> Mobility		
<input type="checkbox"/> Continence		
<input type="checkbox"/> Eating/Drinking		

5. Has the patient been hospitalized or attended to for any other medical condition? Yes (please provide details) No

Name and Addresses of Attending Physician	Date of Consultaion	Diagnosis

6. Does the patient 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", 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

7. Are you the patient's regular attending physician? Yes (please provide details) No

Period of Consultation	Past Health History

8. Please provide details of physicians to whom the patient had been referred, or who attended to the patient.

9. If there is any further information which in your opinion will assist us in assessing this claim, please furnish information below.

3 Signature

Signature of Attending Physician X		Printed Name		
PTR No.	License No.		Field of Specialization	
Address (no., street, municipality)			City	Province
Country	Zip Code	Phone No.	Cell Phone No.	E-Mail Address
Clinic Hours		Date of Signing (day/month/year)		Place of Signing