Sun Life GREPA Financial

Attending Physician's Statement
Advanced Benefit/Terminal Illness/ Living Benefit Rider

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.

Please PRINT clearly.

1 Life Insured Information (to be completed by the patient)

Relating to the Person Insured/Patient

Name (first, middle initial, last)		☐ Male ☐ Female	Date of Birth (day/month/year)
Residence Address (number, street, municipality)			City
Province	Country	Zip Code	Home Phone Number

Business Phone Number	Cell Phone Number	E-mail Address
Sun Life Policy Number ☐ Group, specify:	Certificate No.:	☐ Individual, specify:

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)

2 Specific Information Requested (to be completed by the Attending Physician)

Date of First Visit (day/month/year)	Date of Last Visit (day/month/year)	Frequency of Treatments

Initial Date of Diagnosis (day/month/year)	How long have you been attending the patient?

Names and Addresses of Other Attending Physicians

Name	Address

Diagnosis	Present Condition	Prognosis

2 Specific Information Requested (continued)

Predicted Survival Period (Life Expectancy)	Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Attendant/Precipitating/Aggravating conditions:

Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, E.C.G., or any other special tests with dates).

If hospitalized:

Names and Addresses of Hospitals	Dates Confined (day/month/year)	Other Attending Physicians

How long have you been in active practice?	Are you related to the patient by blood or by affinity? ☐ Yes ☐ No	If so, how?

3 Signature

Your Signature X		Printed Name	
Field of Specialization	License No.	P.T.R. No.	
Address			
City	Province	Country	Zip Code
Business Phone	Cell Phone	E-Mail Address	Fax Number
Date of Signing (day/month/year)		Place of Signing	