

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 the Company.

The purpose of this report is to assist us in making a disability determination. In filling out this report, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination.

Please **PRINT** clearly. Please answer all questions in full.

1 General Information (to be completed by the patient)

Relating to the Life Insured/Patient

Life Insured (Last Name, First Name, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)
Complete Address			Policy Number(s)
Home Phone	Business Phone	Cellphone	Email Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month/Day/Year)

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)

I. History

When did symptoms first appear or when did accident happen? (Month/Day/Year)	When did patient cease work because of incapacity? (Month/Day/Year)
Did patient previously have the same or similar conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please state when and describe the conditions.	
If condition is long standing, how would you describe its evolution since onset? <input type="checkbox"/> Improved <input type="checkbox"/> Remained the Same <input type="checkbox"/> Slight Deterioration <input type="checkbox"/> Significant Deterioration	
Is condition due to injury or sickness arising from patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Smoking Habits Question

Does the patient smoke cigarettes/cigarillos/cigars or consume any other tobacco product?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
a) If "Yes", fill out appropriate box with number per day				
cigarettes	cigars	tobacco	chewing tobacco	other tobacco used
b) If "No", has patient ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", when did the insured stop smoking? <input type="text" value="month/year"/>				



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

Other Attending Physicians

Name of Physician	Address
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II. Diagnosis (including any complications and stage of illness)

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Subjective Symptoms

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Objective Findings (Please attach current x-rays, EKG, laboratory tests and any other clinical findings)

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III. Dates of Treatment

Date of first Visit (Month/Day/Year)	Date of Latest Visit (Month/Day/Year)
Frequency of Visits <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Others (please specify)	

IV. Nature of Treatment

Please include surgery and medications prescribed, if any. If chemotherapy/radiotherapy, please indicate dates & number of sessions.

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V. Progress

Has patient: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Remained Unchanged <input type="checkbox"/> Retrogressed
Is patient: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital Confined
Has patient been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name and address of hospital
Date Admitted (Month/Day/Year) Date Discharged (Month/Day/Year)

VI. Cardiac (If Applicable)

Functional Capacity (American Heart Association) <input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> Class 4 (Complete Limitation)
Blood Pressure (Last Visit) Systolic Diastolic

VII. Physical Impairment

<input type="checkbox"/> Class 1 - No limitation of functional capacity, capable of physical activity (1-10%) <input type="checkbox"/> Class 2 - Slight limitation of functional capacity, capable of light manual activity (15-30%) <input type="checkbox"/> Class 3 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity (35-55%) <input type="checkbox"/> Class 4 - Marked limitation (60-70%) <input type="checkbox"/> Class 5 - Severe limitation of functional capacity, incapable of minimal (sedentary) activity (75-100%)
Is the patient capable of performing activities of daily living (bathing, dressing up, eating, getting in/out of bed, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Remarks

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

VIII. Mental/Nervous Impairment

- Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 - Patient is able to function in most situations and engage in most interpersonal relations (slight limitations)
- Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)

Remarks

IX. Neurological Deficits (If Applicable)

Functional Deficit

Involved Area

Severity: Very Mild Mild Moderate Severe

To what extent has recovery occurred neurologically? Functionally?
 0% 20% 40% 60% 100% Others

Please detail the changes and/or limitations caused by the patient's illness

A. Paralysis/Paresis

B. Speech

C. Sensory

D. Neuro-psychological

Do you consider the neurological deficits to remain during patient's lifetime? Yes No
 If "NO", what type of work would patient be capable of performing after recuperation?
 Own occupation prior to disability
 Other occupation, please specify: _____

X. Prognosis

IS PATIENT CURRENTLY ABLE TO RESUME WORK? (please check appropriate box)

- Yes
 - If yes, On own occupation prior to disability?
 On other occupation?
 - Since when? (Month/Year) _____
- No
 - If no, when do you expect patient to recover to resume work? (Month/Year) _____
 - Can patient resume own occupation prior to disability? Yes No
 - If no, what type of occupation can patient perform? Why?

Other Comments/Remarks

3 Physician's Signature

Signature of Attending Physician X		Printed Name	
PTR No.	License No.	Field of Specialization	
Clinic Address		Clinic Hours/Schedule	
Telephone No.	E-mail Address		
Place of Signing	Date of Signing (Month/Day/Year)		