Declaration of Good Health and Insurability

Sun Life GREPA Financial

In this form, ***you*** and ***your*** refer to the person being insured 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 and the Yuchengco Group of Companies.

PRINT clearly. Use BLACK ink. Indicate N/A if question is not applicable.

1 General Information

Full Name *(Last Name, First Name, Middle Name)*					
Present Residence Address	No., Street, Village/Subdivision, Barangay *(P.O. Box is not acceptable)*	City/Municipality	Province/State	Country	Zip Code
Date of Birth *(day/month/year)*	☐ Male ☐ Female	☐ Single ☐ Legally Separated	☐ Widowed ☐ Married		

2 Health Information

The following questions must be answered by the person being insured.

1. Within the last two (2) years, have any of your applications for insurance been declined, postponed, withdrawn or accepted on a basis other than that applied for? _____ Yes ☐ No ☐
2. Have you had any symptoms of, sought advice for, or been treated for high blood pressure, stroke, heart trouble, diabetes, cancer or tumour, chest pain, viral immunodeficiency illness, bleeding from the bowel, or blood in your sputum, or has treatment for any of these been recommended by a physician or other practitioner? _____ Yes ☐ No ☐
3. Within the last five (5) years, have you been admitted or been advised to be admitted as an in-patient to a hospital or clinic EXCEPT for pregnancy, birth, routine health check-up, gall bladder/kidney stones, colds, flu/influenza, gastroenteritis, upper and lower respiratory tract infections, hepatitis A, appendectomy, tonsillectomy, haemorrhoidectomy, cholecystectomy, and herniotomy? _____ Yes ☐ No ☐
4. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received? For example: persistent fever, unexplained weight loss, loss of appetite, pain or swelling, etc.? _____ Yes ☐ No ☐

If you answered "Yes" to any one (1) of the above questions, please provide further details below:

Physician's Name and Address	Date Seen *(day/month/year)* and Reason for Visit or Diagnosis	Advice or Treatment Received

3 Signatures

By signing, you acknowledge/agree that:

a. To the best of your knowledge and belief that the above answers and those on any attached sheet are complete and true.

b. You authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of you or your health, to give to the Company any and all information about you with reference to your health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment.

c. The Company shall process your personal data to: a) evaluate your application and administer your account; b) process transactions and enforce/fulfill contractual rights/obligations; c) improve the provision of products and services (including improvement in systems and business processes, data analytics, automated processing, etc.); d) comply with legal obligations, as well as laws and regulations (domestic or foreign); and e) manage risks and pursue its legitimate interests, including verification and obtaining additional personal data from third party sources. The Company may disclose your personal data to its affiliates, service providers, and other third parties for processing consistent with the foregoing purposes, who shall be bound by contractual or other reasonable means to protect your personal data.

d. Your personal data shall be retained for the duration of your coverage under your plan or existence of your account(s) and/or upon the later of the expiration of the retention limit set by Company standards, laws and regulations, counted from account closure. You certify that you understand and agree with the declarations and authorizations above and the Company's privacy policy at https://www.sunlifegrepa.com/LegalPrivacySecurity.aspx

e. You will indemnify, hold free and harmless the Company, its affiliates, directors, employees, legal representatives, and assignees against loss and damage from any claims and/or actions made by any third person including the parties to the policy or their representatives in relation to the processing of this application form.

Signature of Employee/Member	Full Name of Employee/Member	
Signature of Witness	Full Name of Witness	Company Name
Place of Signing	Date of Signing *(day/month/year)*	