Employer's Application for Group Insurance

Sun Life GREPA Financial

In the Philippines, this group insurance product is provided by Sun Life Grepa Financial, Inc., a joint venture of Sun Life and the Yuchengco Group of Companies.

In this application, *you* and *your* refer to the Applicant Employer whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life Grepa Financial, Inc.

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

1 General Information

Relating to Applicant Employer

Full Legal Name				
Current Office Address *No., Street, Village/Subdivision, Barangay (P.O. Box is not acceptable)*	City/Municipality	Province/State	Country	Zip Code
Current Office Phone Number *(country code, area code, PTE no. & tel. no.)*	Facsimile Number *(country code, area code, PTE no. & tel. no.)*	T.I.N.		
Nature of Business *(Indicate product or service)*	Source of Funds to pay premium			

Type of Entity

☐ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Others, specify _____

2 Employee Information

☐ Permanent ☐ Probationary ☐ Project-based ☐ Contractual ☐ Others, specify _____

3 Policy Information

Benefits Requested

☐ **Group Yearly Renewable Term**

Rider(s):

- ☐ Accidental Death and Dismemberment
- ☐ Accidental Death, Dismemberment and Disablement
- ☐ Total and Permanent Disability Income
- ☐ Others, specify _____

☐ **Group Personal Accident *(Stand Alone Policy)***

- ☐ Comprehensive Personal Accident
- ☐ Standard Personal Accident

Rider(s):

- ☐ Medical Reimbursement (Accident Only)
- ☐ Burial Benefit
- ☐ Others, specify _____

☐ **Group Hospitalization and Surgical Expense Benefit**

Rider(s):

- ☐ Out-Patient
- ☐ Maternity
- ☐ Others, specify _____

☐ **Contributory** *(75% of all eligible employees)* ☐ **Noncontributory** *(100% of all eligible employees)*	**Mode of Payment** ☐ Annual ☐ Others, specify _____	**Effective Date** *(day/month/year)*
For Group Hospitalization and Surgical Expense Benefit	**Option (Choose one)** ☐ On top of PhilHealth ☐ Independent of PhilHealth	**Availment of Benefit is thru (Choose one)** ☐ Reimbursement ☐ Network Card

4 Additional Information

A. AUTHORIZED SIGNATORY(IES)

Full Name		Date of Birth *(day/month/year)*	
Position/Nature of Work		Place of Birth	
TIN or SSS/GSIS Number		Citizenship(s)/ Nationality	
Contact Number		Sex	
Present Address		E-mail Address	
Permanent Address			

Full Name		Date of Birth *(day/month/year)*	
Position/Nature of Work		Place of Birth	
TIN or SSS/GSIS Number		Citizenship(s)/ Nationality	
Contact Number		Sex	
Present Address		E-mail Address	
Permanent Address			

4 Additional Information (continuation)

B. THIRD PARTY/BENEFICIAL OWNER

A third party/beneficial owner is a person or institution who funds, owns or controls the policy other than the Applicant Employer on whose behalf a transaction or activity is being conducted or has ultimate effective control over a legal person or arrangement.

Is there any Third Party/Beneficial Owner, other than the Applicant Employer, who:

a) funds any of the payment? ☐ Yes ☐ No
b) has access, use or any kind of financial interest in the account? ☐ Yes ☐ No
c) on whose behalf the transaction or activity is being conducted? ☐ Yes ☐ No

If you answered "Yes" to any one (1) of the above questions, kindly complete B.1 (for Individual Third Party/Beneficial Owner) or B.2 (for Entity Third Party/Beneficial Owner)

B.1 Individual Third Party/Beneficial Owner

Individual Full Name			
Occupation/Nature of Work/ Business		Relationship to the Applicant Employer	
Date of Birth *(day/month/year)*		Place of Birth	
Contact Number		Citizenship(s)/Nationality	
Present Address			

B.2 Entity Third Party/Beneficial Owner

Full Business Name			
Nature of Business		Relationship to the Applicant Employer	
Country of Incorporation/ Registration		Date of Incorporation/ Registration *(day/month/year)*	
Current Office Address			

5 Signatures

By signing, you acknowledge/agree that:

a. Subject to approval by the Company, a group policy contract will be issued to you with coverage that will start on the effective date stated in the policy contract. This application form will be attached to and made part of the group policy contract.
b. No employee will become insured unless he/she is Actively-At-Work or actively performing his/her normal daily activities on a full-time basis and have not lost more than two (2) consecutive weeks work as of the effective date of his/her insurance coverage.
c. You will inform us within thirty (30) calendar days of any change in your employees' and your business circumstances and submit the applicable documents accordingly.
d. The Company has a statutory responsibility to provide your information to the appropriate authority.
e. You have obtained each of your employees' consent that the Company shall process each of their personal data and that of their beneficiaries to: a) evaluate the application and administer the 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 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.
f. Personal data shall be retained for the duration of the coverage under the plan or the existence of the 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 have discussed with your employees and they understand and agree with the declarations and authorizations above and the Company's privacy policy at https://www.sunlifegrepa.com/LegalPrivacySecurity.aspx.
g. 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 Authorized Signatory No.1	Full Name of Authorized Signatory	Job Title
Place of Signing	Date of Signing *(day/month/year)*	

Signature of Authorized Signatory No.2	Full Name of Authorized Signatory	Job Title
Place of Signing	Date of Signing *(day/month/year)*	

6 Sales Distributor's (SD) Declaration (For SLGFI Use Only)

I declare and confirm that:

a. I have performed the appropriate know-your-client process in accordance with the anti-money laundering laws and policies of the Company. Should there be any adverse change in my opinion regarding the integrity or reputation of the Applicant Employer, I shall inform the Company's Money Laundering Reporting Officer immediately.

b. I have explained to the Applicant Employer the benefits being applied for in this application in accordance with the provisions of the insurance contract that will be subsequently issued, if approved by the Company.

c. I have asked the questions contained in this application to the authorized representative(s) and the answers were correctly recorded.

d. This application, report and any accompanying information are complete and true to the best of my personal knowledge and belief.

Full Name of SD:		SD Code:
Signature of SD:		Region:
Place of Signing:	Date of Signing *(day/month/year)*:	Sales Unit: