Individual's Application for Group Insurance *(Health Questionnaire)*

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 person being insured 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

Last Name	☐ Male ☐ Female	☐ Mr. ☐ Miss ☐ Mrs. ☐ Others, specify
First Name	☐ Single ☐ Married ☐ Widowed ☐ Legally Separated	
Middle Name	Date of Birth *(day/month/year)*	

Present Residence Address *No., Street, Village/Subdivision, Barangay (P.O. Box is not acceptable)*	City/Municipality	Province/State	Country	Zip Code

Home Phone No. *(country code, area code, PTE no. & tel. no.)*	Work Phone No. *(country code, area code, PTE no. & tel. no.)*	Mobile Phone No. *(country code & mobile no.)*	E-mail Address

Beneficiary(ies)

Full Name (Last Name, First Name, Middle Name)	Date of Birth *(day/month/year)*	Relationship to Member

Note: All nominations of beneficiaries are revocable unless otherwise specified.

2 Health Questionnaire

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 Within the last two (2) years, have any of your applications for insurance been declined, postponed, withdrawn or accepted on a basis other than that applied for?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, 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. The answers and declarations made on this application are complete and true.

b. Your insurance shall become effective in accordance with the terms and conditions of the group policy for which this application is made provided that you are Actively-At-Work or actively performing 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 your insurance coverage and the premium corresponding to your insurance coverage has been paid.

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