

Claimant's Statement (For Covered Critical Illness)

In this form, **you** and **your** refer to the life insured and policy owner 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.

This claim is for: Critical Illness Acceleration Benefit Critical Illness Benefit
 (Check appropriate box) Critical Illness Additional Benefit AEGIS (Term with Dread Disease)

1 General information

Name of Policy Owner (Last Name, First Name, Middle Name)			Date of Birth (month/day/year)
Complete Address P.O. Box is not acceptable (No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code)			
Policy Number(s)			
Home Phone	Business Phone	Mobile Phone	E-mail Address
Name of Life Insured, if other than the Policy Owner (Last Name, First Name, Middle Name)			Date of Birth (month/day/year)
Complete Address P.O. Box is not acceptable (No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code)			
Policy Number(s)			
Home Phone	Business Phone	Mobile Phone	E-mail Address

2 Critical Illness Details (if the space provided is insufficient, please use a separate sheet and attach to the form.)

Describe the nature of the Life Insured's illness	
Date symptoms first occurred (month/day/year)	Date the life insured first consulted a doctor for the illness (month/day/year)
Date the diagnosis of the illness was first made (month/day/year)	Date of surgery, if applicable (month/day/year)
Name of doctor who made the diagnosis	

List names and addresses of all hospitals or physicians consulted regarding the illness.

Names of Physicians/Hospitals	Addresses	Date of Consultation/ Period of Confinement

Name of the life insured's usual medical attendant, if different from above	
Medical Office address	
Contact Number/s	Email-Address



2 Critical Illness Details (continued)

If the space provided is insufficient, please use a separate sheet and attach to the form.

What kind of treatments has the insured received in relation to the illness?

Has the life insured previously suffered from or received treatment for a similar or related illness? Yes No If "Yes", give details:

Names of Physicians/Hospitals	Addresses	Date (month/day/year)	Reason

Have any of the insured's blood relatives suffered from or received treatment for a similar or related illness? Yes No If "Yes", give details:

Relationship	Nature of Illness	Date when first diagnosed (month/day/year)

Is the life insured covered for similar benefits with any other company? Yes No If "Yes", give details:

Name of Insurance Company	Policy Number	Issue Date (month/day/year)	Amount of Benefit

3 Additional Information

Do you smoke cigarettes/cigarillos/cigars or consume any other tobacco product? Yes No

a) If "Yes", fill out appropriate box with quantity per day

cigarettes	e-cigarettes	cigars	others, specify:
------------	--------------	--------	------------------

b) If "No", have you ever smoked a cigarette/cigarillos/cigar or consumed any other tobacco product in the past?

Yes No

If "Yes", when was the last time you smoked a cigarette/cigarillos/cigar or consumed any other tobacco product? (month/year) _____



4 Payment Options

Indicate how you would like to receive the benefit proceeds. Kindly choose from the following options:

Fund Transfer

Credit to your local bank account with the following information:

Account Name _____
 Bank Name _____
 Routing or Serial Number* _____
 Swift Code Number* _____

*not applicable for Peso Account

Telegraphic Transfer (applicable only to a Claimant residing abroad) Convert to US Dollar/Canadian Dollar/Others - specify currency and credit to bank account through overseas transfer with the following information:

Account Number _____
 Bank Address _____

You agree to shoulder any bank fees and charges arising from the foregoing deposit to your account. The Company will not be liable if the remittance is credited to an erroneous bank account number.

You further agree that the company shall not be responsible nor liable whatsoever for any failure, fault or negligence on the part of the bank to deposit the proceeds to your account.

Check (for Peso policy only)

Send through Servicing Advisor at preferred mailing location (automatic if no instruction provided)

For pick-up at Sun Life office (specify the location): _____

For Check - Send by courier/registered mail (specify address): _____

For RCBC Demand Draft - For encashment (provide details below):

Date of Encashment: _____ RCBC Branch Address: _____

RCBC Demand Draft (for US Dollar policy only)

5 Signatures

For AEGIS (Term with Dread Disease), the irrevocable beneficiary/ies and/or assignee/s must sign on this portion.

By signing, you acknowledge/agree that:

- To the best of your knowledge and belief that the above answers and those on any attached sheet are complete and true.
- You authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of you and/or the life insured, or your and/or the life insured's health, to give to the Company any and all information about you and/or the life insured with reference to your and/or the life insured's health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment.
- You agree that the Company can process your personal data to (i) implement your benefit instructions; (ii) enforce/fulfill contractual rights/obligations; (iii) improve how it develops and provides services (including development of and improvement in its systems and business processes, data analytics, automated processing, artificial intelligence, etc.); (iv) comply with applicable laws or regulations whether domestic or foreign; and (v) manage risks and pursue its legitimate interests.
- You also agree that (i) 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; (ii) that your personal data shall be retained for the duration of the policy/ies listed or existence of the related account(s) and/or upon the expiration of the retention limit set by the Company standards, laws and regulations, counted from account closure; and (iii) you have read, understood, and agree with the declarations and authorizations above, including the Company's privacy policy at https://www.sunlifegrepa.com/upload/files/Sun_Life_Grepa_Policy_Privacy_Statement.pdf
- 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.
- You agree that the claims application shall not be considered complete until the submission of all the required documents.

Signature of Policy owner X	Printed Full Name of Policy Owner (Last Name, First Name, Middle Name)
Signature of Life Insured, if other than the Policy Owner X	Printed Full Name of Life Insured (Last Name, First Name, Middle Name)
Place of Signing	Date of Signing (month/day/year)
Signature of Irrevocable Beneficiary, if any X	Printed Full Name (Last Name, First Name, Middle Name)
Signature of Irrevocable Beneficiary, if any X	Printed Full Name (Last Name, First Name, Middle Name)
Signature of Witness X	Printed Full Name (Last Name, First Name, Middle Name)
Place of Signing	Date of Signing (month/day/year)
Residence Address (P.O. Box is not acceptable) No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code	
Home Phone	Work Phone
	Mobile Phone

