

Death Benefit Attending Physician's Statement

In this form, **you** and **your** refer to the physician who attended to the insured, now deceased, while **we, us, our** and the **Company** refer to Sun Life Grepa Financial, Inc. (SLGFI), a joint venture of Sun Life and the Yuchengco Group of Companies.

1 Information about the Life Insured

Name of Life Insured – now deceased (Last Name, First Name, M.I.)	Date of Birth (Month/Day/Year)
Complete Residence Address (P.O. Box is not acceptable)	

2 Details of Death

Cause of Death

If death is due to accident or violent incident, please provide the details below:

Cause of accident/violent incident	Place of accident/violent incident
Date of accident/violent incident (Month/Day/Year)	Time of accident/violent incident
Surgical operation/medical procedure performed, if any	

Was an autopsy or a post-mortem examination made? Yes No If "Yes," please provide details below:

3 Details of Treatment / Consultation

List all the dates when the insured patient consulted and was treated.

Date of Consultation/ Treatment (Month/Day/Year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/Remarks	Medication Prescribed/ Treatment

If the space is insufficient, use the back page of this form.

Was the insured patient or his/her next of kin informed of the above findings/diagnosis? Yes No

Did the deceased insured patient suffer from any other illness, disease, or condition? Yes No If "Yes," please provide details below:

Date of Illness (Month/Day/Year)	Nature of Complaint or Illness	Date Symptoms First Noticed (Month/Day/Year)	Diagnosis/ Remarks	Attending Physician/Hospital	Medication Prescribed/ Treatment

If the space is insufficient, use the back page of this form.

Smoking Habit

To your knowledge, did the insured patient smoke? Yes No If "Yes," please provide details below:

Start date (Month/Day/Year): _____ End date (Month/Day/Year): _____ Until time of death

Source of information: _____ Relationship with the deceased insured: _____

4 Physician's Signature

Signature of Physician X	Printed Full Name	Field of Specialization	PTR & License Nos.
Address	Contact Number	E-mail Address	Date (Month/Day/Year) and Place Signed