Sun Life GREPA Financial

Claimant's Statement (Disability)

Please **PRINT** clearly.

In this form, *you* and *your* refer to the life insured and policyowner while *we, us, our* and *the Company* refer to Sun Life Grepa Financial, Inc., a joint venture of the Sun Life Financial and the Yuchengco Group of Companies.

This claim is for: (Please check appropriate box)
- ☐ Disability of the Insured
- ☐ Disability of the Owner

1 General Information

Life Insured (Last Name, First Name, M.I.) ☐ Male ☐ Female			Date of Birth (Month / Day / Year)
Complete Address			Policy Number(s)
Home Phone	Business Phone	Cellphone	E-mail Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month / Day / Year)

2 Claimant's Statement

What was your occupation on date of onset of your present disability? *(Please check appropriate boxes and provide details if necessary on the blanks provided)*

☐ Employee
- ☐ Clerical / Rank & File — Position Title _____
- ☐ Technical — Position Title _____
- ☐ Supervisory — Position Title _____
- ☐ Middle Management — Position Title _____
- ☐ Senior Management — Position Title _____
- *Office Address _____

☐ Businessman
- ☐ Nature of Business _____
- Business Address _____

☐ Professional
- ☐ Doctor of Medicine ☐ Dentist
- ☐ Nurse / Therapist ☐ Lawyer
- ☐ Engineer / Architect ☐ Teacher / Professor
- Others, specify _____
- *Office Address _____

☐ Housewife

☐ Student — Name of School _____

☐ Others — Specify: _____

Immediately prior to onset of disability, what were the activities related to your work or routine functions? Please check appropriate boxes.

☐ Sitting	☐ Household Chores	☐ Attending To Telephone Calls
☐ Prolonged Standing	☐ Gardening	☐ Attending To Customers (personal)
☐ Frequent Walking	☐ Lifting Heavy Objects	☐ Attend & Conduct Meetings / Seminars
☐ Frequent Climbing	☐ Assembly Line Work (using hands / feet)	☐ Analysis, Judgement & Decision Making
☐ Driving	☐ Furniture / Equipment Repair	☐ Supervision & Management
☐ Travel (land)	☐ Routine Clerical Paper Work	☐ Sales & Marketing (client calls)
☐ Travel (air)	☐ Computer Work	☐ Others _____
☐ Travel (sea)	☐ Cashiering	_____

When did you last work? (Month / Day / Year)
What is the cause of your present disability?
What were the earliest symptoms of your disability?
When did the symptoms firstoccur? (Month / Day / Year)

2 Claimant's Statement (continued)

What is your present state of health? Describe how your condition prevents you from working. (If insured is not working, describe how your condition prevents you from performing your usual activities)

Has such disability existed continously to present date? ☐ Yes ☐ No If "NO", please give particulars

Are you presently confined in a hospital, at home or in bed? ☐ Yes ☐ No If "YES", give dates

Date your physician first treated you for your present disability?	Date you expect to be able to return to work, either full or part time

List names and addresses of all physicians consulted during your present illness

What were the medications your physicians prescribed?

What were the treatment /operations done?

What injuries or illnesses have you had prior to your disability?

What insurances (including those with the Company) do you have with provision for disability benefits? Indicate the name of the company, policy number and benefit type.

Indicate your level of education, including degrees attained, vocational or technical courses taken and occupation for which you are skilled.

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

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

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

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

If "Yes", when was the last time you smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?

month / year

3 Signature

This section must be signed by the life insured and the policyowner, if he/she is not also the person insured.

If claim is for Premium Coverage During Total Disability of Initial Owner, only the policyowner must sign in the space provided for.

By signing below, you hereby confirm that the above statements are true and complete and hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or other organization, or person that has any record or knowledge of you or your health to give the Company any such information. You also consent to a personal investigation. A photographic copy of the authorization shall be as valid as the original.

Signature of Life Insured X	Printed Name
Signature of Policyowner X	Printed Name
Place of Signing	Date of Signing (Month / Day / Year)