Sun Life GREPA Financial

CLAIM FORM FOR TERMINAL ILLNESS BENEFIT

Claimant's Statement

PERSONAL INFORMATION

Name of Life Insured _____ Name of Owner/ Payor _____

Date of Birth _____ Age ____Gender _____ Civil Status _____ Date of Birth _____ Age ____Gender _____
Civil Status _____

Occupation _____ Name of Employer _____ Occupation _____
Tel. No. _____ Tel. No. _____ Name of Employer _____

Address
(Residence)_____ Tel. No._____ Address
(Residence) _____ Tel. No._____

(Business) _____Tel. No._____ (Business) _____Tel. No._____

Relationship of Life Insured to Owner/Payor _____ Policy No. _____

Name of Hospital where confined _____

Address of Hospital _____

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge and belief true, correct and complete.
I hereby authorize any Physician or any Hospital to furnish and disclose all known facts concerning this claim.

Dated at _____this _____ day of _____, 20__

_____

Signature over Printed Name of Life Insured