Sun Life GREPA Financial

# Attending Physician's Statement
## (Advanced Benefit/Terminal Illness/Living Benefit Rider)

In this form, "*you*" and "*your*" refer to the policyowner, life insured, patient and the physician 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 Financial and the Yuchengco Group of Companies.

The patient is responsible for the completion of this form without expense to Sun Life Grepa Financial, Inc.

Please PRINT clearly.

## 1 General information

Relating to the Person Insured/Patient

| Name (first, middle initial, last) ☐ Male ☐ Female | | | Date of Birth (day/month/year) |
|---|---|---|---|
| Residence Address (number, street, municipality) | | | City |
| Province | Country | Zip Code | Home Phone Number |

| Business Phone Number | Cell Phone Number | E-mail Address |
|---|---|---|
| Sun Life Policy Number<br>☐ Group, specify: | Certificate No.: | ☐ Individual, specify: |

Authorization:

By signing below, you agree that SLGFI (the "Company") shall process your personal and sensitive personal information to evaluate, process, and implement the transaction or request that you have initiated. The Company may disclose your personal and sensitive personal information to its affiliates, service providers, and other third parties for processing consistent with the foregoing purpose, and to comply with legal obligations, as well as laws and regulations (domestic or foreign).

Your rights include the right to be informed, access your data, and rectify errors in your data. For more information about your rights and how we protect your data, you may access our privacy policy at https://www.sunlifegrepa.com/privacy-policy-statement. Should you have any concerns in relation to your rights or the processing of your personal and sensitive personal information, you may get in touch with our Data Protection Officer at privacyconcern@sunlifegrepa.com.

| Signature of Patient (or Parent, if minor) | Printed Name of Patient/Parent | Date of Signing (day/month/year) |
|---|---|---|
| | | |

## 2 Specific Information Requested (to be completed by the Attending Physician)

| Date of First Visit (day/month/year) | Date of Last Visit (day/month/year) | Frequency of Treatments |
|---|---|---|
| Initial Date of Diagnosis (day/month/year) | How long have you been attending the patient? | |

Names and Addresses of Other Attending Physicians

| Name | Address |
|---|---|
| | |

| Diagnosis | Present Condition | Prognosis |
|---|---|---|
| | | |

## 2 Specific Information Requested (continued)

| Predicted Survival Period (Life Expectancy) | Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No |
|---|---|
| | |

Attendant/Precipitating/Aggravating conditions:

Objective findings supporting the diagnosis and prognosis (include any results of histopath, current X-rays, E.C.G., or any other special tests with dates).

If hospitalized:

| Names and Addresses of Hospitals | Dates Confined (day/month/year) | Other Attending Physicians |
|---|---|---|
| | | |

| How long have you been in active practice? | Are you related to the patient by blood or by affinity? ☐ Yes ☐ No | If so, how? |
|---|---|---|
| | | |

## 3 Signature

| Your Signature<br>X | Printed Name |
|---|---|

| Field of Specialization | License No. | P.T.R. No. |
|---|---|---|

| Address |
|---|

| City | Province | Country | Zip Code |
|---|---|---|---|
| Business Phone | Cell Phone | E-Mail Address | Fax Number |

| Date of Signing (day/month/year) | Place of Signing |
|---|---|