Sun Life GREPA Financial

Claimant's Statement
(Accidental Dismemberment & Disablement)

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 Life Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco Group of Companies.

This claim is for:
(Please check appropriate box)

- ☐ Accidental Dismemberment & Disablement (ADD&D)
- ☐ Accidental Dismemberment Benefi t (AX)
- ☐ Accidental Indemnity Benefit (AI)
- ☐ Basic Accident Rider (BAR)
- ☐ Comprehensive Accident Rider (CAR)

1 General Information

Relating to the Life Insured

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

2 Details of the Accident

When did it happen? (Date and Time)	Where did it happen?
How did it happen? (Give full particulars)	
What was the nature of occupation immediately prior to the accident? (Describe the usual and customary duties of your occupation)	

Type of claim

- ☐ Disablement/Disability - proceed to the next page
- ☐ Dismemberment - specify loss below

Losses suffered by the Life Insured		Date of Loss (month/day/year)
☐ sight of one eye	☐ both eyes	_____
☐ hearing of one ear	☐ both ears	_____
☐ one hand	☐ both hands	_____
☐ one arm	☐ both arms	_____
☐ four fingers & thumb of one hand	☐ index finger	_____
☐ four fingers	☐ middle finger	_____
☐ thumb	☐ ring finger	_____
☐ metacarpals of 1st and 2nd (additional)	☐ little finger	_____
☐ metacarpals 3rd, 4th or 5th (additional)		
☐ one foot	☐ both feet	_____
☐ one leg	☐ both legs	_____
☐ all toes on one foot		_____
☐ big toe		_____
☐ any toe, other than big toe, each		_____

2 Details of the Accident (continued)

Names and addresses of all physicians who attended you for the injuries sustained and period of treatment.

Physician's Name & Address	Inclusive date of confinement	Nature of Injuries

Name of regular attending physician during your confinement/treatment.

3 Claimant's Statement

Names and addresses of hospital, clinic or other institution where you had been confined and received treatment.

Name of hospital, clinic or institution	Date of confinement/consultation	Nature of Injuries

Are you still confined by doctor's order? If "Yes", check if confined to:

☐ hospital ☐ home ☐ bed	Since when? (month/day/year) From:	To:	When do you expect to be able to resume work?

Are you covered with similar benefits with any other company? ☐ Yes ☐ No If "Yes", give details:

Name of Insurance Company	Policy Number	Benefi t Type

Have you filed claims under these benefits? ☐ Yes ☐ No

Does the patient 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

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

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

month/year

4 Payment Options

Indicate how you would like to receive the death 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)

☐ **RCBC** Demand Draft (for US Dollar 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: _____

5 Signatures

By signing, you acknowledge/agree that:

a. To the best of your knowledge and belief that the above answers and those on any attached sheet are complete and true.

b. 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.

c. 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.

d. 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.

e. You also agree that (i) the Company may disclose your personal data to its affi liates, 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/privacy-policy-statement/.

f. You agree that the claims application shall not be considered complete until the submission of all the required documents.

Signature of Life Insured, if age is sixteen (16) and over X	Printed Full Name of Life Insured (Last Name, First Name, Middle Name)
Signature of Parent, if Life Insured is under eighteen (18) years of age X	Printed Full Name of Parent (Last Name, First Name, Middle Name)
Place of Signing	Date of Signing (month/day/year)

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