Sun Life GREPA Financial

# Personal Declaration of Insurability
## (age 16 & over)

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

Please PRINT clearly. Use BLACK ink.

| Application by (name of policy owner) | For the ☐ Reinstatement ☐ Delivery ☐ Change |
|---|---|
| of Policy No. | on the life of |

## 1 General Information

### Relating to the Life Insured/Policy Owner

| Last Name | First Name | Middle Name |
|---|---|---|
| Sex ☐ Male ☐ Female | Birthdate (day/month/year) | Birthplace (City/Province and Country) |
| Citizenship/s | Age | Religion |

| Country/ies of Legal Residence other than the Philippines | ID Presented | ID No. | ID Expiry Date |
|---|---|---|---|
| | | | |

| TIN | SSS No. or GSIS No. | Explain if there is no TIN. SSS or GSIS No. |
|---|---|---|
| | | |

| Permanent Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable |
|---|
| |

| Present Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable |
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| Business Address (building, street, municipality/city, province, country, zip code) P.O. Box is not acceptable |
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| Home Phone (country code, area code & tel. no.) | Work Phone (country code, area code & tel. no.) | Mobile Phone (country code & mobile no.) | E-mail Address |
|---|---|---|---|
| | | | |

| If residence address is outside the Philippines, since when? (day/month/year) |
|---|
| |

| Is there any intention to reside outside the Philippines? ☐ Yes ☐ No |
|---|

| Occupation - please indicate specific job | Have you changed your occupation since the date of application for the policy? ☐ Yes ☐ No If "Yes," since when? (day/month/year) |
|---|---|
| | |

### Relating to Business Policy Owner

| Company/Business Name | Relationship to the life insured ☐ Employer ☐ Others, specify _____ |
|---|---|
| | |

| Country of Incorporation or Business Registration | Type of Business ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Others _____ | TIN |
|---|---|---|
| | | |

| Contact Person | Designation |
|---|---|
| | |

| Business Address (building, street, municipality, city/province, country, zip code) P.O. Box is not acceptable |
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| Business Phone (country code, area code, tel. no.) | |
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| | |

## 2 Personal and Non-Medical Questions on the Life Insured / Policy Owner

| Height ft. in. | Weight lbs. | Weight change of more than 5 lbs. in the past 2 years? ☐ Gain lbs. ☐ Loss lbs. ☐ No change | Reason |
|---|---|---|---|
| Name of regular attending physician (First Name, Last Name) | | | |
| Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable | | | |
| City | Province | Country | Zip Code |

**If the answer to question #3 is "yes", please complete an Aviation form.**

1. Are you presently disabled by illness, injury or otherwise prevented from performing on a full time basis any of the duties of your occupation? ..... ☐ Yes ☐ No
2. Do you intend to engage in any hazardous occupational or sporting activities?..... ☐ Yes ☐ No
3. Except for travel as a fare-paying passenger, have you flown an aircraft during the past 2 years or do you intend to do so? ..... ☐ Yes ☐ No
4. Since the date of application for this policy, has any application for, or reinstatement of life, health or accident insurance been declined, postponed, modified or rated up by Sun Life Grepa Financial, Inc., its affiliates or other insurance company? ..... ☐ Yes ☐ No

**If the answer to questions 1-4 is "yes", please provide details below.**

| Question No. | |
|---|---|
| | |

5. Do you have other life insurance policies in-force or pending with the Company and other insurance companies? ☐ Yes (Provide details below) ☐ No

| Year Issued | Amount of Insurance | Status (in-force or pending) |
|---|---|---|
| | | |

Total Insurance Coverage ☐

6. In the last 12 months, have you smoked or used cigarettes, e-cigarettes, cigarillos, cigars, pipes, betelnut, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ☐ Yes (Provide details below) ☐ No

| Product | Quantity per Day | Frequency of Use | Date Last Used |
|---|---|---|---|
| Cigarettes | | | |
| E- Cigarettes | | | |
| Cigars | | | |
| Others | | | |

7. Are you on a diet, or taking any vitamin, herbal medicine, reducing pills, or other medicine of any kind? ..... ☐ Yes ☐ No
8. Have you , during the past 2 years, been examined or treated for high blood pressure, stroke, heart trouble, diabetes, mass, growth, tumor, cancer, chest pain or had such treatment been recommended by a physician or other practitioner? ..... ☐ Yes ☐ No

## 2 Personal and Non-Medical Questions on the Life Insured / Policy Owner (continued)

9. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received? ..... ☐ Yes ☐ No

10. For Women:
    a) Are you pregnant? (Number of months: ) ..... ☐ Yes ☐ No
    b) Have you had any complications of pregnancy? ..... ☐ Yes ☐ No
    c) Do you have or have you ever had any gynecologic problem? ..... ☐ Yes ☐ No

11. Within the past 5 years (or since the date of application for this policy, if more recent,) have you:
    a) consulted any doctor or other health practitioner?..... ☐ Yes ☐ No
    b) been told you had, or sought advice for any illness, disease or injury? ..... ☐ Yes ☐ No
    c) submitted to ECG, X-rays, blood test or other tests?..... ☐ Yes ☐ No
    d) been admitted or advised to be admitted as an in-patient in a hospital or clinic except for pregnancy, birth or routine health check-up? ..... ☐ Yes ☐ No
    e) ever used shabu, cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines except as prescribed by a physician? ..... ☐ Yes ☐ No
    f) ever had or sought advice for Acquired Immune Deficiency Syndrome (A.I.D.S.) or a test indicating the presence of H.I.V. virus? ..... ☐ Yes ☐ No

**If the answer to questions 7-11 is "yes", please provide details below. (use Amendment of Application if necessary)**

| Question No. | Physician's Name & Complete Address | Date Seen (day/month/year) | Reason for Visit or Diagnosis | Advice or Treatment Received | Results after checkup or Treatment |
|---|---|---|---|---|---|
| | | | | | |

## 3 Acknowledgment and Agreement

This section must be signed by the policy owner, the life insured and the parent, if applicable.

A person below 18 years old must be represented by his parent or legal guardian.

By signing, you declare that to the best of your knowledge and belief the above answers are full and true; and agree that, this application if approved, with the answers given in any other declaration which may be required by *us* and which relates to the insurability of the life insured or to the change of the policy, shall be the basis of such reinstatement, delivery or change. You agree that:

(1) *the Company* shall incur no liability by reason of this application or by reason of any cash paid or settlement made in connection therewith, until this application has been approved by *the Company* with no change having taken place in the insurability of the life insured subsequent to the date of this application,

(2) all material facts, being facts which might influence the assessment of this Application have been disclosed on this Application, it being understood that failure to make such disclosure renders the contract voidable, and

(3) if on the basis of this application, the policy is changed so as to result in an increase in the amount at risk, death by suicide within a period of years from the date of this application equal to the period specified in the Suicide Provisions of the policy, is a risk not assumed under the changed policy in respect of any increase in the amount at risk; but in the event of such death *the Company* will become liable to make payment of the amount which would have become payable had the policy not been changed, together with the increase in the premiums paid as a result of the change.

## 3 Acknowledgment and Agreement (continued)

(4) By affixing your signature below, you acknowledge and agree that you shall notify the Company in writing and provide the required details or documents within thirty (30) days for any changes in your personal/material information which results in the Company being subject to tax reporting and withholding requirements under local and/or foreign laws applicable to you or your property. There is a change in your personal/material information if there is a change in your contact number(s), place of residence, citizenship, or other circumstance as defined under applicable laws.

(5) By signing below, you expressly authorize the collection, processing, use, storage and destruction of your personal/sensitive personal information and any related information as well as its sharing, transfer and/or disclosure to any of the Company's branches, subsidiaries, affiliates, agents and representatives, industry associations and third parties such as but not limited to outsourced service providers, external auditors, and local and foreign regulatory authorities in relation to any matter including but not limited to those involving anti-money laundering and tax monitoring, review and reporting, statistical and risk analysis, provision of any products, service, or offers made through mail/email/fax/SMS/telephone, customer satisfaction surveys; compliance with court and other lawful orders and requirements. You shall hold the Company free and harmless from any liability that may arise from any transfer, disclosure, processing, collection, use, storage or destruction of said information.

(6) Your rights include the right to be informed, access your data, rectify errors, object to processing, and file a complaint. 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 data, you may get in touch with our Data Protection Officer at privacyconcern@sunlifegrepa.com.

(7) You hereby authorize any physician, hospital, clinic, insurance company or other organization, institution, or person that has any personal record of you and/or the life insured to give to the Company any and all information about you and/or the life insured including but not limited to personal and sensitive personal information and other information with reference to your and/or the life insured's health and medical history and any hopitalization, advice, diagnosis, treatment, disease or ailment. This information is required for, and may be sought during evaluation of the risk associated with your and/or the life insured's application for life insurance, administration and continuing service of your and/or the life insured with products that cater to your and/or the life insured's needs at any given point in time;

(8) You also authorize the Company to have your and/or the life insured's blood and urine samples analyzed for the purpose of underwriting your application for your insurance coverage and/or that of the life insured. The analysis of the blood and urine sample may include, but not limited to, tests where allowed by law, for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of immune disorder or the presence of medication, drugs or nicotine; and

(9) You consent to a personal investigation on you and/or the life insured, and copy of the authorization granted in these documents shall be as valid as the orginal.

For corporate policy owner, the name and title of the signing officer is requested.

| | |
|---|---|
| Signature of Policy Owner (required if policy owner is not also the life insured)<br>X | Signature of life insured (required if life insured is 16 years and over)<br>X |
| Name of Authorized Signatory | Signature of Parent (required if life insured is below 18 years old)<br>**X** |
| Title of Authorized Signatory | Printed Name of Parent |
| Signature of Witness<br>X | Name of Witness |
| Address of Witness (no., street, municipality/city, province, country, zip code) | |
| Place of Signing | Date of Signing (day/month/year) |

## Agent's Report

**About the Life Insured** (age 16 & over)

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|---|---|
| 1. a) Has this application been secured by personal interview with the life insured? ☐ Yes ☐ No If not, how was it secured? | b) If this application is intended for reinstatement, please indicate the reason for lapse. |
| 2. Have you ever heard anything concerning the life insured's past or present health, medical history, smoking habits, alcohol consumption, drug use (e.g. shabu, or the like) or any risk factor that would have an adverse effect on life insured's insurability? ☐ Yes ☐ No If so, give particulars. | |
| 3. Does the life insured appear to be in good health and have a normal appearance? ☐ Yes ☐ No | 5. To your knowledge, has the life insured changed residence during the past 5 years? ☐ Yes ☐ No If so, give previous addresses. |
| 4. Estimate of Annual Income | |

**Payment Information**

| Is payment included with application? ☐ Yes ☐ No | P.R. No. | P.R. Date (day/month/year) | P.R. Amount |
|---|---|---|---|

**Agent's Information**

| Name of Agent | Code | Region |
|---|---|---|
| Signature of Agent X | | Date (day/month/year) |

## For Company Use only

If form is received through mail by home office staff, indicate

| Date Received (day/month/year) | Name of receiving staff | Signature of receiving staff X |
|---|---|---|

If form is received by counter staff, please indicate:

| Date & Time Received ☐ AM. ☐ P.M. | Name of receiving staff | Signature of receiving staff X |
|---|---|---|

and answer the following:

a) Was this application secured by personal interview with the life insured? ☐ Yes ☐ No
If so, indicate

| Date of Interview (day/month/year) | Name of interviewing staff | Signature of interviewing staff **X** |
|---|---|---|

b) If this application was not secured by personal interview with the life insured, how was it secured? Submitted by the life insured's representative? ..... ☐ Yes ☐ No, If "No," indicate how it was secured in the box "Others, specify".

| Name of Representative | | | |
|---|---|---|---|
| Address (no., street, municipality) | | | |
| City | Province | Country | Zip Code |

Others, specify.

## Underwriting Department

| Medical Information Bureau for Life Insured (age 16 and over) ☐ Co ☐ NIL With Reinsurance? ☐ Yes ☐ No | Date Checked (day/month/year) |
|---|---|
| Searched by: Staff's Signature **X** | Staff's Printed Name |