

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

As your partner for life, we know that your health is your foremost priority during these times and we would like to help you focus on your recovery by expediting the processing of your claim. Please take note of the following reminders so we can process your claim swiftly.

- Accomplish and submit the completed form and all applicable claim requirements through any of our Client Service Centers or email to phil_claims@sunlife.com. Incomplete information and/or documents will affect the processing of your claim.
- Write legibly using capital letters. Write N/A if question is not applicable.
- Mark the box(es) with a "✓" to indicate your choice(es) then sign the form only when completely filled out.
- Refrain from using third parties to process your claims.

Fraud Warning

P.D. No. 612 or The Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both to any person who makes any fraudulent claim, or fraudulently prepares claim requirements.

1 Information about the Life Insured

Name of Life Insured (Last Name, First Name, M.I.)	Policy Number(s)	Date of Birth (month/day/year)
Complete Residence Address (P.O. Box is not acceptable)	Contact Number(s)	E-mail Address

2 Details of Condition

Symptoms experienced and signs noticed	Date symptoms and signs first experienced and noticed
Details of physician who was first consulted for these symptoms and signs (Name of Physician, Contact Number(s), E-mail address)	Date of consultation
Diagnosis (if applicable, please indicate the stage)	
Details of physician who was first consulted for this diagnosis (Name of Physician, Contact Number(s), E-mail address)	Date of diagnosis
Treatment(s) received for this condition	Date of treatment(s)
Surgery/procedure	Date of surgery/procedure

Did you consult other physicians for this condition? Yes No If "Yes," please provide the details below:

Name of Physician	Contact Number(s)	E-mail address
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Date of Consultation (month/day/year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (month/day/year)	Diagnosis/Remarks	Hospital	Medication Prescribed/Treatment

If the space is insufficient, use the back page of this form.

By signing, you acknowledged/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 to the processing of your personal and sensitive information for the additional purposes of evaluating your claim and implementing your request/instructions herein in accordance with Sun Life Grepa's Privacy Policy available at <https://online.sunlife.com.ph/privacy>, reaffirm your consent to the processing of your personal data as recorded in your most recent insurance application form, and acknowledge that such consent continues to be in full force and effect.
- 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://online.sunlife.com.ph/privacy>. 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@sunlife.com.
- e. You agree that the claims application shall not be considered complete until the submission of all the required documents.

Signature over Printed Full Name of Life Insured	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Policy Owner (if other than the Life Insured)	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (moth/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (moth/day/year)	Place Signed
Signature over Printed Full Name of Guardian (if Life Insured/Policyowner is a minor or has mental disability)	Date Signed (month/day/year)	Place Signed