Sun Life GREPA Financial

Mental Incapacity Benefit

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

This form is used to appoint the Mental Incapacity Benefit Recipient and elect the Mental Incapacity Benefit Option of your policy, and shall form part of your policy contract.

Please write legibly using **capital letters**. Write **N/A** if question is not applicable. Mark the box(es) with an "**X**" to indicate your choice(s) then sign the form only when completely filled out.

A General Information

1. Policy Owner (Last Name, First Name, Middle Name)
2. Policy Number(s)

B Mental Incapacity Benefit Recipient (MIBR) and Mental Incapacity Benefit Option (MIBO) Change Details

☐ Appoint your MIBR and elect your MIBO
Complete items 3 to 13, then proceed to items 16 and onwards

☐ Remove your appointed MIBR
Complete item 14, then proceed to items 17 and onwards

☐ Update the Information of your MIBR
Complete item 15, then proceed to items 17 and onwards

☐ Change your MIBO
Complete items 16 and onwards

B.1 Appoint the Mental Incapacity Benefit Recipient

Kindly complete the needed information below to appoint the Mental Incapacity Benefit Recipient to your policy.

3. Full Name (Last Name, First Name, Middle Name)			4. Sex (at Birth)
5. Date of Birth (e.g. 01-JAN-2026) Day – Month – Year		6. Country of Birth	
7. Citizenship/Nationality	8. Relationship to the life insured	9. Home Phone Number	10. Mobile Phone Number
11. Complete Address [No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country (P.O. Box is not acceptable)]			
12. Occupation		13. Nature of Business	

B.2 Remove the Mental Incapacity Benefit Recipient

Kindly complete the needed information below to remove the Mental Incapacity Benefit Recipient to your policy.

14. Full Name (Last Name, First Name, Middle Name)

B.3 Update the Information of the Mental Incapacity Benefit Recipient

Kindly complete the information below to update or correct any existing Mental Incapacity Benefit Recipient information.

15. Mental Incapacity Benefit Recipient Full Name (Last Name, First Name, Middle Name)

☐ Full Name — Last Name, First Name, Middle Name

☐ Other Legal Name — Last Name, First Name, Middle Name

☐ Birthdate (e.g. 01-JAN-2026) — Day – Month – Year

☐ Country of Birth

☐ Citizenship/Nationality

☐ Complete Address

☐ Contact Information

B.4 Mental Incapacity Benefit Option

Kindly **select one** of the Mental Incapacity Benefit Options below.

16. ☐ Dividends (Pays the available cash value of any dividend credits less any advances with interest.)*
☐ Surrender (Pays the available guaranteed value of your policy plus the cash value of any dividend credits less any advances with interest. This option will terminate your policy.)

*Provided that your policy has no existing third-party payor, and while the life insured is suffering from Mental Incapacity, Coma, or Major Head Trauma, the Mental Incapacity Benefit Recipient may act as third-party payor of premiums, advances with interest and any other amounts required to continue your policy in force.

Notes:

1. Subject to the approval of the Company, and provided that the life insured has not been diagnosed with Mental Incapacity, Coma, or Major Head Trauma, you may accomplish this Mental Incapacity Benefit Recipient form during the life of your policy, provided the following requirements are met:

   a) you and the life insured are the same person at the time you apply for the designation of the Mental Incapacity Benefit Recipient; and
   b) the Mental Incapacity Benefit Recipient must be:
      i. at least eighteen (18) years old at the time you apply for the designation of the Mental Incapacity Benefit Recipient; and
      ii. your spouse, legitimate or illegitimate children, parents, brothers or sisters of the full blood, brothers or sisters of the half-blood, or common-law partner, provided that the latter is not disqualified from being appointed as a beneficiary under a life insurance contract; and
   c) satisfactory evidence of the proposed Mental Incapacity Benefit Recipient is submitted to the Company; and
   d) the irrevocable beneficiaries and assignee, if any, must agree in writing to the requested designation of the Mental Incapacity Benefit Recipient.

2. Subject to the approval of the Company, the appointment or the revocation of the Mental Incapacity Benefit Recipient and the elected Mental Incapacity Benefit Option shall be deemed effective as of the date of the Company's receipt of the request and complete requirements. If no appointment is made nor option is elected, the Mental Incapacity Benefit is not payable.

3. The existing Mental Incapacity Benefit Recipient designation will be automatically revoked if any of the following occurs:

   a) you apply for the designation of the new Mental Incapacity Benefit Recipient and it is approved by the Company; or
   b) you are no longer the insured; or
   c) you are no longer the owner of the policy; or
   d) the Company is notified that there is a judicial guardian appointed for the life insured; or
   e) the Company is notified that you have an enduring power of attorney covering your policy.

4. Revocation of the appointment of the Mental Incapacity Benefit Recipient shall result in the revocation of the elected Mental Incapacity Benefit Option.

C Compliance with Regulatory Requirements

17. Has there been any change in your citizenship/nationality or country of legal residence?

☐ Yes, you are a citizen/national and a legal resident of _____ (specify country).

☐ Yes, you are a citizen/national of _____ (specify country) but you legally reside in _____ (specify country).

☐ None.

D Signatures

By signing, you confirm your understanding and agreement to the following:

a. You will inform us within 30 calendar days of any change in your circumstances, including but not limited to citizenship/nationality, and submit the applicable documents accordingly.

b. You acknowledge the Company's statutory responsibility to provide your information, including but not limited to local or foreign tax status, to the appropriate authority.

c. You acknowledge that the Company, its employees, duly authorized representatives, related companies, third party service providers, and vendors shall process and share your and the insured's information, with any person or organization to (i) service this account, (ii) process transactions and enforce the contract, and (iii) pursue its legitimate and lawful rights and interests and other purposes allowed under laws and regulations, including, but not limited to, those relating to data privacy and anti-money laundering.

d. Your personal data shall be retained throughout the existence of your account(s) and/or until expiration of the retention limit set by laws and regulations from account closure and the period set for destruction or disposal of records. You certify that you have read, understood, and agreed with the declarations and authorizations above, including the Company's privacy policy found in https://www.sunlifegrepa.com/privacy-policy-statement/

e. 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.

f. You agree to indemnify and hold free and harmless the Company, its affiliates, directors, employees, legal representatives, and assignees against loss and damage from any claims and/or actions made by any third person including the parties to this policy or their representatives in relation to the processing of this request.

g. You declare that, to the best of your knowledge, the information that is found in this form and declaration is complete and accurate.

For Policy Owner or Assignee/Authorized Signatory, if any.

18. Signature of Policy Owner	19. Printed Name
20. Signature of Assignee, if any (For Lender Institution)	21. Printed Name and Job Title
22. Signature of Irrevocable Beneficiary, if any	23. Printed Name
24. Signature of Irrevocable Beneficiary, if any	25. Printed Name
26. Signature of Irrevocable Beneficiary, if any	27. Printed Name
28. Signature of Witness	29. Printed Name
30. Place of Signing	31. Date of Signing (e.g. 01-JAN-2026) Day Month Year

32. Would you like to receive personalized communication and product offers from the Company and related parties that may help with your financial needs?

☐ Yes ☐ No

For Company Use Only