Employee's Application for Group Insurance

Please PRINT clearly.
Use BLACK ink.

In the Philippines, group insurance products are provided by Sun Life of Canada (Philippines), Inc., a member of Sun Life Financial group of companies.

In this application, *you* and *your* refer to the person being insured, the Employee, while *we*, *us*, *our* and *the Company* refer to Sun Life of Canada, (Philippines), Inc.

1 General Information

Relating to Employee

Please check the appropriate box for the Type of Insurance applied for.

Please provide complete address; do not use P.O. box.

Last Name	☐ Male ☐ Female	☐ Mr. ☐ Mrs	☐ Miss ☐ Others, specify
First Name	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		
Middle Name	Birthdate (day/month/year)	Age (last birthday)	
Other Legal Names (a.k.a.)	Type of Group Insurance Applied For ☐ Term Life ☐ Personal Accident		
Residence Address (no., street, municipality)			
City	Province	Country	Zip code
Occupation	Basic Salary		
Name of Employer	Date Employed (day/month/year)		
Business Address (no., street, municipality)			
City	Province	Country	Zip code
Home Phone	Business Phone	Cell Phone	E-mail Address

Please indicate beside each named beneficiary if revocable or irrevocable.

If the space provided is insufficient, please use separate sheet and attach to the application.

Beneficiary

Primary Beneficiary/ies for proceeds as they become due on death

Name (First Name, MI, Last Name)	Date of Birth (day/month/year)	Relationship to Employee

Contingent Beneficiary/ies in event of death of all primary beneficiaries

Name (First Name, MI, Last Name)	Date of Birth (day/month/year)	Relationship to Employee

2 Signatures

By signing below, you hereby agree that your insurance will become effective in accordance with the terms of the plan as outlined in the Group Policy provided that you are Actively-At-Work on such date and the premium corresponding to your insurance coverage has been paid. You also authorize your Employer named above to deduct from your salary or wages the amount required as your contributions, if any.

Signature of Employee X	Printed Name
Signature of Witness X	Printed Name
Place of Signing	Date of Signing (day/month/year)

3 For Company Use Only

Policy No.	Certificate No.	Effective Date