Claimant's Statement (Death Benefit)

Sun Life Financial

In this form, "*you*" and "*your*" refer to the claimants/authorized representative of claimants whose information we are processing or disclosing. *We, us, our* and *the Company* refer to Sun Life of Canada (Philippines), Inc., a member of the Sun Life Financial group of companies.

The employment of a third person, on commission or otherwise, for the collection of an approved claim is unnecessary. Settlement is achieved most speedily by direct communication with a local representative of the Company.

All questions must be answered in full.

Please PRINT clearly.

1 General Information

Name of Insured - now deceased (Last Name, First Name, M.I.)
Policy Number(s)

2 Information regarding the Deceased Insured

If age has not been admitted by the Company, please provide evidence satisfactorily establishing date of birth.

Date of Birth (month/day/year)	Place of Birth
Date of Death (month/day/year)	Place of Death
Occupation at time policy was issued	Occupation at time of death
Complete Residence Address at time policy was issued	
Complete Residence Address at time of death	

State all facts regarding the cause and circumstances of death

How long was the insured ill?	Give date of first indication of failing health (month/day/year)

Please attach press clippings and the Coroner's report if an inquest was held.

Did the insured have any illness previously? ☐ Yes ☐ No If "YES", please provide details

Did the insured use intoxicating liquors? ☐ Yes ☐ No	Did the insured use them to excess? ☐ Yes ☐ No
How long before death did the deceased use them to excess?	

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

Did the insured 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", did the life insured ever smoke a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... ☐ Yes ☐ No

If "Yes", when did the insured stop smoking? month/year

2 Information regarding the Deceased Insured (continued)

Names and Addresses of Physicians consulted by the insured within the last 5 years.

Did the insured ever claim any total disability, sickness or accident benefits under any insurance contract within the last 5 years?
☐ Yes ☐ No If "YES", provide details

Did the insured have any other life insurance? ☐ Yes ☐ No If "YES", state company/ies and issue date of policy/ies

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

3 Foreign Account Tax Compliance Act (FATCA) Questions

1. Are you a U.S. Citizen? ☐ Yes ☐ No
2. Are you a tax resident of the U.S. because you hold a green card (permanent resident card)? ☐ Yes ☐ No
3. Are you a tax resident of the U.S. under the substantial presence test*? ☐ Yes ☐ No

* To meet this test, you must be physically present in the United States (U.S.) on at least:
1. 31 days during the current year, and
2. 183 days during the 3-year period that includes the current year and the 2 years immediately before that, counting:
   - All the days you were present in the current year, and
   - 1/3 of the days you were present in the first year before the current year, and
   - 1/6 of the days you were present in the second year before the currrent year.

In compliance with the tax law of the Republic of the Philippines, a client that is a U.S. person (U.S. citizen, tax resident, including green card holder) must complete IRS Form W-9 within thirty (30) days from date of signing of this form. Otherwise, any client whose account contains "U.S. indicia" must complete IRS Form W-8BEN or W-8BEN-E and in certain cases, submit other documentary evidence within thirty (30) days from date of signing of this form or your account will be reported to the Bureau of Internal Revenue (BIR).

With regard to the above, you agree that when we are required by law, regulation or otherwise to provide all information on your local and/or foreign tax status and your account(s), we may disclose such information to competent authority or its delegate involved in processing, collecting, transferring or disclosing the relevant information. Where a separate waiver is required to provide the required information to competent authority or its delegate, you undertake to provide a waiver in a format acceptable to us.

4 Information Regarding the Claimant and Signatures

This section must be signed by the claimants/authorized representative of claimants. If a claimant is a minor (under 18 years of age), the guardian for the minor must sign. Additional requirements may be required from the said guardian and advice will be given accordingly.

By signing below, you allow us to process and disclose your and/or the life insured's personal and sensitive personal information to third parties for the following purposes:(a) the processing of this form; and (b) the administration of your claim with the Company.

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 hospitalization, advice, diagnosis, treatment, disease or ailment.

You consent to a personal investigation on you and/or the life insured, and copy of the authorization granted in this form shall be as valid as the original.

If you need more information about our privacy policy, please visit https://apps.sunlife.com.ph/privacy.

Please complete one box per claimant. If you are an executor, administrator or guardian, please attach a certified copy of appointment.

Name (Last, First, Middle)		Date of Birth (month/day/year)
Citizenship/s	Place of Birth (City/Province/State and Country)	Countries of Legal Residence other than Philippines
Permanent Residence Address (P.O. Box is not acceptable) (No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code)		
Present Address (P.O. Box is not acceptable) (No., Street, Village/Subdivision, Barangay, City/Municipality, Province/State, Country, Zip Code)		
Philippine TIN	U.S. TIN	Other TIN

ID Presented/Submitted	I.D. No.	I.D. Expiry Date
Home Phone (country code, area code & tel. no.)	Work Phone (country code, area code & tel. no.)	Relationship to the Insured
Claimant's Signature X	Date of Signing (month/day/year)	Place of Signing

For Witness to the signature/s of Claimant/s, please provide complete address and contact nos. on the space provided below. The witness should be a disinterested person to the Claimant.

Signature of Witness X	Printed Name
Place of Signing	Date of Signing (month/day/year)
Residence Address	
Home Phone/Fax/Business/Cell Phone	