Claimant's Statement (Hospital Income Benefit)

Sun Life Financial

Please PRINT clearly.
Use BLACK ink.
If with erasures, please countersign.

In this form, *"you"* and *"your"* refer to the life insured and policyowner 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.

1 General Information

Relating to the person insured

Policy Number/s		
Name (Last Name, First Name, M.I.)	☐ Male ☐ Female	Date of Birth (Month/Day/Year)
Residence Address		
Contact Number/s		E-mail Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)		

2 Life Insured's Declaration

1. Reason for Confinement: ☐Illness ☐ Accident
2. What physical conditions/symptoms/complaints led you to seek hospital confinement?

3. Was the confinement at your request? ☐ Yes ☐ No If No, who recommended the confinement?

4. If due to accident, please provide details of the accident.

Date (month/day/year) and time of accident	Where did the accident happen?
Describe how the accident happened.	

5. Were there witnesses to the accident?two witnesses. ☐Yes ☐ No If yes, please give name(s) and address(es) of one or

Name of Witness (Last Name, First Name, M.I.)	
Residence Address	Contact Number/s

Name of Witness (Last Name, First Name, M.I.)	
Residence Address	Contact Number/s

3 Details of Treatment

1. Date physician was first seen for this condition: (Month/Day/Year)

2. Give the name and address of physician first seen for this condition.

Name	
Medical Office Address	
Contact Number/s	E-mail Address

3. Give the name and address of hospital where you were confined.

Name	
Medical Office Address	
Contact Number/s	E-mail Address

Confined from: Date (Month/Day/Year) and Time Admitted	Through: Date (Month/Day/Year) and Time Discharged

4. Give the name and address of the physician who recommended this confinement/hospitalization.

Name (Last Name, First Name, M.I.)	
Medical Office Address	
Contact Number/s	E-mail Address

5. Give the names and addresses of physicians who treated you at the hospital:

Name and address of Doctor	Field of Specialization

6. Who of the above-named doctors was your regular attending physician during your confinement/ hospitalization:

7. Were you confined in the Intensive Care Unit?If ☐Yes ☐ No
yes, state inclusive dates of I.C.U. confinement.

From (Month/Day/Year)	To (Month/Day/Year)	Please indicate the type of ICU

8. Name of physician who advised confinement in the I.C.U.

9. Do you 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”, have you ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?.....☐Yes☐ No
If “Yes”, when was the last time you smoked a cigarette/cigarillo/ cigar or consumed any other tobacco product month/year

4 Additional Information

1. If confinement is due to illness, have you seen a physician for this condition or a similar/related condition in the past? . . . . ☐ Yes ☐ No
   If yes, please give name(s) and address(es) of physician(s)

consulted: Name and address of Doctor	Approximate Dates of Consultation (Month/Day/Year)

2. Have you sought medical advice/been treated/taken medication and/or been hospitalized for the same or similar/related illness/condition in the past? ☐ Yes ☐ No

Name of Doctor	Approximate Dates of Consultations (Month/Day/Year)	Medications Prescribed/Taken
Name of Hospital	**Approximate Dates of Confinements (Month/Day/Year)**	**Name of Attending Physician**

3. Do you have other existing hospital insurance? ☐ Yes ☐ No If yes, please give name of insurer(s):

4. Do you have other life insurance with hospitalization benefits? ☐ Yes ☐ No
   If yes, please give name of insurer(s):

5. Have you filed claims under these hospitalization insurance? If yes, as of this date, have these been settled? ☐ Yes ☐ No ☐ Yes ☐ No

5 Signatures

By signing below, you allow us to process and disclose your personal and sensitive personal information to third parties so that we can better help you meet your lifetime needs.

You also consent to a personal investigation on you and a 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.

This section must be signed by the person insured, the parent if applicable, and the policyowner if he or she is not the person insured.

Signature of Life Insured, if age is 16 and over X	Printed Name X
Signature of Parent if life insured is below 18 years old X	Printed Name X
Signature of Policyowner if other than the life insured X	Printed Name X
Place of Signing X	Date (Month/Day/Year)

Signature of Witness X	Printed Name
Address	Contact Number/s
Place of Signing	**Date (Month/Day/Year)**