Claimant's Statement (Female and Maternity Benefits)

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 Life Insured Information

Policy Number/s	
Name (Last Name, First Name, M.I.)	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 Female Benefit Claim Information

This claim is for: (Please choose from the list of Female Benefits below)

- ☐ Cancer of the
  - ☐ Breast
  - ☐ Cervix Uteri
  - ☐ Uterus
  - ☐ Ovary
  - ☐ Fallopian Tube
  - ☐ Vagina
- ☐ Carcinoma-in-situ of the
  - ☐ Uterine Corpus
  - ☐ Fallopian Tube
  - ☐ Ovary
  - ☐ Vagina
- ☐ Systemic Lupus Erythematosus
- ☐ Rheumatoid Arthritis
- ☐ Severe Osteoporosis
- ☐ Hysterectomy
- ☐ Dilatation and Curettage
- ☐ Major Plastic Surgery Due to Accidental Burning
- ☐ Skin Transplantation Due to Accidental Burning

3 Maternity Benefit Claim Information

This claim is for (Please choose from the list of Maternity Benefit below)

- ☐ Pregnancy Complications
  - ☐ Disseminated Intravascular Coagulation (D.I.C.)
  - ☐ Ectopic Pregnancy
  - ☐ Hydatidiform Mole

4 Claim Details

Provide full and exact details of diagnosis	
Date symptoms first occurred (month/day/year)	Date the insured first consulted a doctor for the condition (month/day/year)
Date the diagnosis of the condition was first made (month/day/year)	Name of doctor who made the diagnosis
Date of surgery, if applicable (month/day/year)	

4 Claim Details (continued)

List names and addresses of physicians consulted or hospitals where confined for the condition

Name of Physician &/or Hospital	*Address*	*Date of Consultations &/or Confinement*

Give the name and address of the insured's usual medical attendant if different from above.

What kind of treatment has the insured received in relation to the condition?

Has the insured previously suffered from or received treatment for a similar or related condition? If "Yes", give details ☐ Yes ☐ No

Name of Physician &/or Hospital	*Address*	*Date*	*Reason*

Has the insured previously suffered from any other illness or condition? If "Yes", give details ☐ Yes ☐ No

Diagnosis	Date when first diagnosed	Name of attending doctor

Does 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", has the insured ever smoked a cigarretes/cigarillos/cigars or consume any other tobacco product in the past? ☐ Yes ☐ No
If "Yes", when was the last time the insured smoked a cigarrette/cigarillo/cigar or consumed any other tobacco product? month/year

Is the insured covered for similar benefits with any other company? ☐ Yes ☐ No If "Yes", give details

Name of Insurance Company	*Issue Date*	*Amount of Benefit*

5 Signatures

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

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.

Signature of Life Insured X	Printed Name
Signature of Policy Owner (if not also life insured) X	Printed Name
Place of Signing	Date of Signing (month/day/year)

Signature of Witness X	Printed Name	
Address		Contact Number/s
Place of Signing	Date of Signing (month/day/year)	