Claimant's Statement
(Critical Condition Rider/Critical Illness Benefit)

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

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

Policy Number (s)	
Policy Owner (Last Name, First Name, M.I.)	Date of Birth (month/day/year)
Mailing Address	
Contact Number/s	E-mail Address
Life Insured, if different from Policy Owner (Last Name, First Name, M.I.)	Date of Birth (month/day/year)
Mailing Address	
Contact Number/s	E-mail Address

2 Critical Condition Details

Provide full and exact details of diagnosis	
Date symptoms first occured (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)	

List names and addresses of all hospitals or physicians consulted regarding the condition

Names of Physicians/Hospitals	Addresses	Date of Consultation/Period of Confinement

Name of the insured's usual medical attendant, if different from above	
Medical Office address	
Contact Number/s	E-mail Address

2 Critical Condition Details (continued)

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

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

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

Names of Physicians/Hospitals	Addresses	Date	Reason

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

Diagnosis	Date when first diagnosed	Name of attending doctor

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

Name of Insurance Company	Policy No	Issue Date	Amount of Benefit

3 Additional Information

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", did you ever smoke 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 Signatures

This section must be signed by the policy owner, the life insured and the appropriate person as indicated.

For Sun Life Assure, all the irrevocable beneficiaries must also sign this form and witnessed by an Advisor or Staff of Sun Life Financial. Two (2) valid Proofs Of Identity of the irrevocable beneficiaries, Advisor or Staff must be attached.

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 Policy Owner X	Signature of Life Insured, if different from Policy Owner
Place of Signing	Date of Signing (month/day/year)

Signature of Irrevocable Beneficiary, if any X	Printed Name
Signature of Irrevocable Beneficiary, if any X	Printed Name

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