Claimant's Statement
(Accidental Dismemberment & Disablement)

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 life insured

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 (LastName, FirstName, M.I.) (Please complete if policyowner is other than the life insured)	

2 Details of the Accident

When did it happen? (Date and Time)	Where did it happen?
How did it happen? (give full particulars)	
What was the nature of occupation immediately prior to the accident? (describe the usual and customary duties of your occupation)	

Type of Claim

☐ Disablement

☐ Dismemberment - specify loss:

Losses suffered by the insured		Date of Loss (month/day/year)
☐ sight of one eye	☐ both eyes	
☐ hearing of one ear	☐ both ears	
☐ one hand	☐ both hands	
☐ one arm	☐ both arms	
☐ four fingers & thumb of one hand	☐ index finger	
	☐ middle finger	
☐ four fingers	☐ ring finger	
☐ thumb	☐ little finger	
☐ metacarpals of 1st and 2nd (additional)		
☐ metacarpals 3rd, 4th or 5th (additional)		
☐ one foot	☐ both feet	
☐ one leg	☐ both legs	
☐ all toes on one foot		
☐ big toe		
☐ any toe other than big toe, each		

2 Details of the Accident (continued)

Names and addresses of all physicians who attended you for the injuries sustained and period of treatment.

Physician's Name & Address	Inclusive date of confinement	Nature of Injuries

Name of regular attending physician during your confinement/treatment.

3 Claimant's Statement

Names and addresses of hospital, clinic or other institution where you had been confined and received treatment.

Name of hospital, clinic or institution	Date of confinement/consultation	Nature of Injuries

Are you still confined by doctor's order? If "yes", please check if confined to:

☐ hospital ☐ home ☐ bed	Since when? From: To:	When do you expect to be able to resume work?

Are you covered with similar benefits with any other company? ☐ Yes ☐ No If "yes", please give details:

Name of Insurance Company	Policy No.	Benefit Type

Have you filed claims under these benefits? ☐ Yes ☐ No

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 Signatures

This section must be signed by the person insured, the parent, if applicable and the policyowner if he/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 Inusred, if age is 16 and over	Signature of Policy Owner (if not also the Life Insured)
Signature of Parent, if Life Insured is below 18 years of age X	Signature of Parent, if Life Insured is below 18 years of age X
Place of Signing X	Date of Signing (month/day/year) X

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