Claimant's Statement (SUN Fit and Well)

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

PRINT clearly. Use BLACK ink. Indicate N/A if question is not applicable. If with erasures, please countersign.

1 General Information

Policy Number/s	Occupation
Policy Owner (Last Name, First Name, M.I)	Date of Birth (month/day/year)
Complete 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)
Occupation	
Complete Mailing Address	
Contact Number/s	E-mail Address

2 Critical Condition 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)	Date of surgery, if applicable (month/day/year)
Name of the doctor who made the diagnosis	

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

2 Critical Condition Details (cont.)

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 Number	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", 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 you and all your irrevocable beneficiaries 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.

Data Privacy and Authorization

Medical Information Database

In accordance with the Insurance Commission's Circular Letter No. 2016-54, your medical information will be uploaded to a Medical Information Database accessible to life insurance companies for the purpose of enhancing risk assessment and preventing fraud. Once uploaded, all life insurance companies will only have limited access to your information in order to protect your right to privacy in accordance with law. A copy of Circular Letter No. 2016-54 may be accessed at the Insurance Commission's website at www.insurance.gov.ph

Authorization to Process Your Personal Data

You understand and acknowledge that the Company, its employees, duly authorized representatives, related companies, third party service providers and vendors, shall use, process and share your information, including sensitive personal information, with any person or organization to (i) administer and service this insurance or investment account; (ii) process claims and enforce/fulfill contractual rights/obligations; or (iii) for other reasonable purposes related to the provision of products and services (including but not limited to improvement/upgrade in systems and business processes, data analytics, automated processing, etc.).

The Company may further process your information for purposes of complying with its legal obligations, laws and regulations (including but not limited to the Anti Money Laundering Act and Credit Information Systems Act); pursue its legitimate and lawful rights and interests; and other purposes allowed under privacy laws and regulations.

Your personal data shall be retained throughout the duration of your coverage under your plan or existence of your account(s) and/or until expiration of the retention limit set by laws and regulations from account closure and the period set for destruction or disposal of records. You certify that you have read, understood and agree with the declarations and authorizations above, including Sun Life's privacy policy found in https://apps.sunlife.com.ph/privacy.

Would you like to receive personalized communications, products, and service offers from the Company, Sun Life Asset Management Company, Inc. (SLAMCI) and related parties that may help with your financial needs? ☐ Yes ☐ No

Signature of Policy Owner X	Signature of Life Insured if other than Policy Owner X
Date and Place of Signing	Date and Place of Signing

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	
Place of Signing	Date of Signing (month/day/year)