Evidence of Insurability Questionnaire for Excess Premiums

Sun Life Financial

Please PRINT clearly.
Use BLACK ink.

In this form, *you* and *your* refer to the person insured and the policyowner while *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

Application by (Name of Policyowner, Last, First, M.I.)	
for the Excess Premiums amounting to ☐ Php ☐ US$	under Policy Number
on the life of	

2 Declaration and Representation

The following questions must be answered by the person insured.

YES	NO		
☐	☐	1.	Within the last 2 years, have you had or been told you have or sought advice for high blood pressure, stroke, chest pain, heart attack, heart murmur, diabetes, urinary, reproductive or prostate disorder, sexually transmitted disorder, mass, cancer or tumor, epilepsy, psychological disorder, chronic cough, tuberculosis, emphysema, ulcerative colitis, hepatitis B & C, convulsions, epilepsy or loss of consciousness, positive HIV test, Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex?
☐	☐	2.	Within the last 2 years, have you had any test results, or routine check up, or had ecg, x-ray, urine, blood tests or other tests which resulted in abnormal results?
☐	☐	3.	Do you have any health symptoms or complaints for which a physician has not been consulted? If "Yes", please provide details below.

Give full details to any "Yes" answer to questions 1 and 2 in the space provided for:

Physician's Name and Address	Date Seen (day/month/year) and Reason for Visit or Diagnosis	Diagnosis, Medication and results of treatment

3 Signatures

By signing below,

a) you declare to the best of your knowledge and belief that the above answers are complete and true;
b) you hereby authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of you or your health, to give to Sun Life of Canada (Philippines), Inc. any and all information about you with reference to your health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment.

Place of Signing	Date (day/month/year)
Policyowner's Signature X	Printed Name
Life Insured's Signature X	Printed Name
Witness X	Name of Witness