Request for Change in Premium Rate Basis

Sun Life Financial

Please PRINT clearly.
Use BLACK ink.

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

You hereby request that the Company recalculate the premium rate basis for the policy indicated below subject to our evaluation of the answers to the questions in the Declaration Section.

1 General Information

Please complete if the life insured is not also the policy owner.

Policy Owner (Last Name, First Name, M.I.)	
Life Insured (Last Name, First Name, M.I.)	
Policy Number	NBO

2 Declaration

This section must be answered by the life insured, if not also the policy owner. The life insured must also undergo a Cotinine test.

1. Does the life insured smoke cigarettes/cigarillos/cigars or consume any other tobacco product? ☐ Yes ☐ No
   a) If "Yes", fill out appropriate box with number per day

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

   b) If "No", has the life insured ever smoked a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... ☐ Yes ☐ No
   If "Yes", when was the last time the life insured smoked a cigarette/cigarillo/cigar or consumed any other tobacco product? month/year

2. Is the life insured presently disabled by illness, injury or otherwise prevented from performing on a full time basis any of the duties of his/her occupation?..... ☐ Yes ☐ No

3. Has the life insured ever had, or been told he had, or sought advice for : (*encircle appropriate item*)
   a) chest pain, stroke, high bood pressure, heart attack or any disease of the heart?..... ☐ Yes ☐ No
   b) asthma , chronic cough or lung disorder?..... ☐ Yes ☐ No
   c) diabetes, cancer, tumor or kidney disorder?..... ☐ Yes ☐ No
   d) ulcer, colitis or liver disorder?..... ☐ Yes ☐ No
   e) acquired immune deficiency syndrome (AIDS) or presence of HIV?..... ☐ Yes ☐ No

4. Is the life insured under treatment on diet, medicine or any other means?..... ☐ Yes ☐ No

Give full details of all "Yes" answers in the space provided for.

Question	Physician's Name and Address	Date Seen	Reason for Visit or Diagnosis	Advice or Treatment Received

3 Signatures

By signing below, you hereby declare that to the best of your knowledge and belief, the above answers are full and true; and agree that this request, if approved, with the answers given in any other declaration which may be required by the Company relating to the insurability of the life insured or to the change of the policy, shall be the basis of that change. You also agree that this request, together with any declaration, will form part of the changed policy.

This section must be signed by the policy owner, the life insured, if not also the policy owner, and by the appropriate person as indicated.

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

Signature of Policy Owner	Printed Name
X	

Signature of Life Insured, if other than Owner	Printed Name	Date of Signing (day/month/year)
X		

Signature of Witness	Printed Name	Date of Signing (day/month/year)
X		

4 For Company Use Only