

Claimant's Statement (Female and Maternity Benefits)



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 Life Insured Information

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 (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)	

2 Female Benefit Claim Information

This claim is for: (Please choose from the list of Female Benefits below)

<input type="checkbox"/> Cancer of the	<input type="checkbox"/> Uterus	<input type="checkbox"/> Fallopian Tube
<input type="checkbox"/> Breast	<input type="checkbox"/> Ovary	<input type="checkbox"/> Vagina
<input type="checkbox"/> Cervix Uteri		
<input type="checkbox"/> Carcinoma-in-situ of the	<input type="checkbox"/> Ovary	
<input type="checkbox"/> Uterine Corpus	<input type="checkbox"/> Vagina	
<input type="checkbox"/> Fallopian Tube		
<input type="checkbox"/> Systemic Lupus Erythematosus		
<input type="checkbox"/> Rheumatoid Arthritis		
<input type="checkbox"/> Severe Osteoporosis		
<input type="checkbox"/> Hysterectomy		
<input type="checkbox"/> Dilatation and Curettage		
<input type="checkbox"/> Major Plastic Surgery Due to Accidental Burning		
<input type="checkbox"/> Skin Transplantation Due to Accidental Burning		

3 Maternity Benefit Claim Information

This claim is for (Please choose from the list of Maternity Benefit below)

<input type="checkbox"/> Pregnancy Complications
<input type="checkbox"/> Disseminated Intravascular Coagulation (D.I.C.)
<input type="checkbox"/> Ectopic Pregnancy
<input type="checkbox"/> Hydatidiform Mole

4 Claim 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)	Name of doctor who made the diagnosis
Date of surgery, if applicable (month/day/year)	



List names and addresses of physicians consulted or hospitals where confined for the condition			
<i>Name of Physician &/or Hospital</i>	<i>Address</i>	<i>Date of Consultations &/or Confinement</i>	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
Give the name and address of the insured's usual medical attendant if different from above.			
What kind of treatment has the insured received in relation to the condition?			
Has the insured previously suffered from or received treatment for a similar or related condition? If "Yes", give details			<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Name of Physician &/or Hospital</i>	<i>Address</i>	<i>Date</i>	<i>Reason</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Has the insured previously suffered from any other illness or condition? If "Yes", give details			<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Diagnosis</i>	<i>Date when first diagnosed</i>	<i>Name of attending doctor</i>	
_____	_____	_____	
Does the insured smoke cigarettes/cigarillos/cigars or consume any other tobacco product? <input type="checkbox"/> Yes <input type="checkbox"/> No			
a. If "Yes", fill out appropriate box with quantity per day.			
cigarettes	E-cigarettes	cigars	others
_____	_____	_____	_____
b. If "No", has the insured ever smoked a cigarettes/cigarillos/cigars or consume any other tobacco product in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", when was the last time the insured smoked a cigarette/cigarillo/cigar or consumed any other tobacco product?			month/year
_____			_____
Is the insured covered for similar benefits with any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give details			
<i>Name of Insurance Company</i>	<i>Issue Date</i>	<i>Amount of Benefit</i>	
_____	_____	_____	

This section must be signed by the life insured and the policyowner, if he or 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 Insured X	Printed Name
Signature of Policy Owner (if not also life insured) X	Printed Name
Place of Signing	Date of Signing (month/day/year)
Signature of Witness X	Printed Name
Address	Contact Number/s
Place of Signing	Date of Signing (month/day/year)