

Claimant's Statement (Disability)



Please **PRINT** clearly.

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.

This claim is for: Total Disability Benefit on the life insured
 (Please check appropriate box) Premium Coverage Upon Death or During Total Disability of Initial Owner

1 General Information

Life Insured (Last Name, First Name, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year)
Complete Address			Sun Life Policy Number(s)
Home Phone	Business Phone	Cellphone	E-mail Address
Policyowner (Last Name, First Name, M.I.) (Please complete if policyowner is other than the life insured)			Date of Birth (Month/Day/Year)

2 Claimant's Statement

What was your occupation on date of onset of your present disability? *(Please check appropriate boxes and provide details if necessary on the blanks provided)*

Employee

Clerical/Rank & File
 Technical
 Supervisory
 Middle Management
 Senior Management

Position Title _____
 Position Title _____
 Position Title _____
 Position Title _____
 Position Title _____

*Office Address _____

Businessman

Nature of Business _____
 Business Address _____

Professional

Doctor of Medicine
 Nurse/Therapist
 Engineer/Architect

Dentist
 Lawyer
 Teacher/Professor

Others, specify _____
 *Office Address _____

Housewife

Student Name of School _____

Others Specify: _____

Immediately prior to onset of disability, what were the activities related to your work or routine functions? Please check appropriate boxes.

Sitting
 Prolonged Standing
 Frequent Walking
 Frequent Climbing
 Driving
 Travel (land)
 Travel (air)
 Travel (sea)

Household Chores
 Gardening
 Lifting Heavy Objects
 Assembly Line Work (using hands/feet)
 Furniture/Equipment Repair
 Routine Clerical Paper Work
 Computer Work
 Cashiering

Attending To Telephone Calls
 Attending To Customers (personal)
 Attend & Conduct Meetings/Seminars
 Analysis, Judgement & Decision Making
 Supervision & Management
 Sales & Marketing (client calls)
 Others _____

When did you last work? (Month/Day/Year)

What is the cause of your present disability?

What were earliest symptoms of your disability?

When did the symptoms first occur? (Month/Day/Year)



2 Claimant's Statement (continued)

What is your present state of health? Describe how your condition prevents you from working. (If insured is not working, describe how your condition prevents you from performing your usual activities)

Has such disability existed continuously to present date? Yes No If "NO", please give particulars

Are you presently confined in a hospital, at home or in bed? Yes No If "YES", give dates

Date your physician first treated you for your present disability _____ Date you expect to be able to return to work, either full or part time _____

List names and addresses of all physicians consulted during your present illness

What were the medications your physicians prescribed?

What were the treatment/operations done?

What injuries or illnesses have you had prior to your disability?

What insurances (including those with the Company) do you have with provision for disability benefits? Indicate the name of the company, policy number and benefit type.

Indicate your level of education, including degrees attained, vocational or technical courses taken and occupation for which you are skilled.

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
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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

3 Signature

This section must be signed by the life insured and the policyowner, if he/she is not also the person insured.

If claim is for Premium Coverage Upon Death or During Total Disability of Initial Owner, only the policyowner must sign in the space provided for.

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 Policyowner X	Printed Name
Place of Signing	Date of Signing (Month/Day/Year)