

# Claimant's Supplementary 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<br><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

If the space provided is insufficient, please use a separate sheet and attach to the form.

|   |
|---|
| Describe your present condition and how you feel generally.   |
| Has there been any change in your condition since the last report? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "YES", please describe  |
| Describe your current daily routine, including specific activities you are involved with or any tasks you can perform.  |
| Are you working? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>If "YES", <input type="checkbox"/> Part-Time<br><input type="checkbox"/> Full-Time<br>Since when? _____  |
| Has your doctor indicated when you will be able to resume full-time or even part-time work? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "YES", please give the date your doctor has suggested and any restrictions he has recommended. |
| Describe what still prevents you from returning to work   |
| List names and addresses of all physicians consulted during your present illness, what medications they prescribed and treatment done   |
| Describe any changes that have been made in your treatment (i.e. medication, frequency of treatment, physiotherapy, etc.)   |

## 3 Signature

This section must be signed by the life insured and the policyowner, if he/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>.

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.

|                                |                                  |
|--------------------------------|----------------------------------|
| Signature of Life Insured<br>X | Printed Name                     |
| Signature of Policyowner<br>X  | Printed Name                     |
| Place of Signing               | Date of Signing (Month/Day/Year) |

