Personal Declaration of Insurability

(child under age 16)

Sun Life Financial

In this form *you* and *your* refer to the policy owner, the parent, as the case may 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.

Please PRINT clearly. Use BLACK ink.

Application by (name of policy owner)	For the ☐ Reinstatement ☐ Delivery ☐ Change
of Policy No.	on the life of

1 General Information

Relating to the child insured

Last Name	First Name	Middle Name
Sex ☐ Male ☐ Female	Birthdate (day/month/year)	Birthplace (City/Province and Country)
Citizenship/s	Age	Religion
Country/ies of Legal Residence other than the Philippines		
Permanent Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable.		
Present Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable.		
If residence address is outside the Philippines, since when? (day/month/year)	Is there any intention to reside outside the Philippines? ☐ Yes ☐ No If "Yes", please provide details.	

2 Personal and Non-Medical Questionnaire on the child insured

The following questions must be answered by a parent who lives with the child, if not also the policy owner.

Height ft. in.	Weight lbs.	Weight change of more than 5 lbs. in the past year? ☐ Gain lbs. ☐ Loss lbs. ☐ No Change	Reason
Name of regular attending physician (First Name, Last Name)			
Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable.			
City	Province	Country	Zip Code

1. Are there other life insurance policies in-force or pending with the Company and other insurance companies?
☐ Yes (Provide details below) ☐ No

Year Issued	Amount of Insurance	Status (in-force or pending)

Total Insurance Coverage

2. Since the date of application for this policy has any application for, or reinstatement of life, health, or accident insurance been declined, postponed, modified or rated up by Sun Life of Canada (Philippines), Inc., Sun Life Assurance Company of Canada, their affiliates, or other insurance company? ..... ☐ Yes ☐ No
If "Yes," please provide details.

2 Personal and Non-Medical Questionnaire on the child insured (continued)

3. Is the child under treatment by diet, medicine, drugs or any other means? ..... ☐ Yes ☐ No
4. During the past 2 years has the child been examined or treated by, or consulted a physician or other practitioner for any congenital birth disease? ..... ☐ Yes ☐ No
5. Does the child have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received? ..... ☐ Yes ☐ No
6. Within the past 5 years (or since the date of application for this policy, if more recent), has the child:
   a) consulted any physician or health practitioner? ..... ☐ Yes ☐ No
   b) had, or been told he had, or sought advice for any illness, disease of injury? ..... ☐ Yes ☐ No
   c) submitted to ECG, x-rays, blood test or other tests? ..... ☐ Yes ☐ No
   d) been admitted or advised to be admitted as an in-patient in a hospital or clinic? ☐ Yes ☐ No
   e) ever had or sought advice for Acquired Immune Deficiency Syndrome (A.I.D.S) or a test indicating the presence of H.I.V. virus? ..... ☐ Yes ☐ No

If the answer to questions 3-6 is "yes", please provide details below. (use Amendment of Application if necessary)

Question No.	Physician's Name & Complete Address	Date Seen (day/month/year)	Reason for Visit or Diagnosis	Advice or Treatment Received	Results after check up or Treatment

3 General Information

The following questions under Sections 3 & 4 must be answered by the policy owner if the policy has a waiver of premium benefit.

Relating to the policy owner

Last Name	First Name	Middle Name	
Sex ☐ Male ☐ Female	Birthdate (day/month/year)	Birthplace (City/Province and Country)	
Citizenship/s	Age	Religion	
Country/ies of Legal Residence other than the Philippines	ID Presented	ID No.	ID Expiry Date
TIN	SSS No. or GSIS No.	Explain if there is no TIN, SSS or GSIS No.	
Permanent Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable			
Present Residence Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable			
Business Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable			
Home Phone (country code, area code & tel. no.)	Work Phone (country code, area code & tel. no.)	Mobile Phone (country code & mobile no.)	E-mail address
If residence address is outside the Philippines, since when? (day/month/year)			
Is there any intention to reside outside the Philippines? ☐ Yes ☐ No If "Yes", please provide details.			
Occupation - please indicate specific job	Have you changed your occupation since the date of application for the policy? ☐ Yes ☐ No If "Yes," since when? (day/month/year)		

4 Personal and Non-Medical Questionnaire on the policy owner

Height	Weight	Weight change of more than 5 lbs. in the past 2 years?	Reason
ft. in.	lbs.	☐ Gain lbs. ☐ Loss lbs. ☐ No change	

Name of regular attending physician (First Name, Last Name)

Address (no., street, municipality/city, province, country, zip code) P.O. Box is not acceptable

City	Province	Country	Zip Code

If the answer to question # 3 is "yes", please complete an Aviation form.

1. Are you presently disabled by illness, injury or otherwise prevented from performing on a full time basis any of the duties of your occupation? ..... ☐Yes ☐No
2. Do you intend to engage in any hazardous occupational or sporting activities? ..... ☐Yes ☐No
3. Except for travel as a fare-paying passenger, have you flown an aircraft during the past 2 years or do you intend to do so? ..... ☐Yes ☐No
4. Since the date of application for this policy, has any application for, or reinstatement of life, health or accident insurance been declined, postponed, modified or rated up by Sun Life of Canada (Philippines), Inc. or other insurance company? If "yes" provide details below ..... ☐Yes ☐No

If the answer to questions 1-4 is "yes", please provide details below.

Question No.	

5. Do you have other life insurance policies in-force or pending with the Company and other insurance companies? ☐Yes (Provide details below) ☐No

Life to be insured	Year Issued	Amount of Insurance	Company	Personal or Business	Status (in-force or pending)

Total Insurance Coverage

6. In the last 12 months, have you smoked or used cigarettes, e-cigarettes, cigarillos, cigars, pipes, betelnut, chewing tobacco, nicotine gum or patches, or nicotine or tobacco in any other form? ☐Yes (Provide details below) ☐No

Product	Quantity per Day	Frequency of Use	Date Last Used
Cigarettes			
E- Cigarettes			
Cigars			
Others			

7. Are you on a diet, or taking any vitamin, herbal medicine, reducing pills, or other medicine of any kind? ..... ☐Yes ☐No
8. Have you , during the past 2 years, been examined or treated for high blood pressure, stroke, heart trouble, diabetes, mass, growth, tumor, cancer, chest pain or had such treatment been recommended by a physician or other practitioner? ..... ☐Yes ☐No
9. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received? ..... ☐ Yes ☐No
10. For Women:
    a) Are you pregnant? (Number of months:) ..... ☐Yes ☐No
    b) Have you had any complications of pregnancy? ..... ☐Yes ☐No
    c) Do you have or have you ever had any gynecologic problem?..... ☐Yes ☐No

4 Personal and Non-Medical Questionnaire on the policy owner (continued)

11. Within the past 5 years (or since the date of application for this policy, if more recent,) have you:

a) consulted any doctor or other health practitioner? ☐ Yes ☐ No
b) been told you had, or sought advice for any illness, disease or injury? ☐ Yes ☐ No
c) submitted to ECG, X-rays, blood test or other tests? ☐ Yes ☐ No
d) been admitted or advised to be admitted as an in-patient in a hospital or clinic except for pregnancy, birth or routine health check-up? ☐ Yes ☐ No
e) ever used shabu, cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines except as prescribed by a physician? ☐ Yes ☐ No
f) ever had or sought advice for Acquired Immune Deficiency Syndrome (A.I.D.S.) or a test indicating the presence of H.I.V. virus? ☐ Yes ☐ No

Please provide details below for *yes* answers to questions 7 to 11. (use Amendment of Application if necessary)

Question No.	Physician's Name & Complete Address	Date Seen (day/month/year)	Reason for Visit or Diagnosis	Advice or Treatment Received	Results after check up or Treatment

5 Acknowledgment and Agreement

This section must be signed by the policy owner.
By signing below, you declare that to the best of your knowledge and belief the above answers are full and true; and agree that, this application if approved, with the answers given in any other declaration which may be required by *us* and which relates to the insurability of the life insured and of the owner if the policy includes a waiver of premium benefit or to the change of the policy, shall be the basis of such reinstatement, delivery or change. You agree that:

(1) *the Company* shall incur no liability by reason of this application or by reason of any cash paid or settlement made in connection therewith, until this application has been approved by *the Company* with no change having taken place in the insurability of the life insured and of the owner if the policy includes a waiver of premium benefit subsequent to the date of this application,

(2) all material facts, being facts which might influence the assessment of this Application have been disclosed on this Application, it being understood that failure to make such disclosure renders the contract voidable, and

(3) if on the basis of this application, the policy is changed so as to result in an increase in the amount at risk, death by suicide within a period of years from the date of this application equal to the period specified in the Suicide Provisions of the policy, is a risk not assumed under the changed policy in respect of any increase in the amount at risk; but in the event of such death *the Company* will become liable to make payment of the amount which would have become payable had the policy not been changed, together with the increase in the premiums paid as a result of the change.

(4) you acknowledge and agree that you shall notify the Company in writing and provide the required details or documents within thirty (30) days for any changes in your personal/material information which results in the Company being subject to tax reporting and withholding requirements under local and/or foreign laws applicable to you or your property. There is a change in your personal/material information if there is a change in your contact number(s), place of residence, citizenship, or other circumstance as defined under applicable laws.

(5) you consent as well as affirm that you are authorized to give consent on behalf of your child for the collection, processing, use, storage and destruction of you/your child's personal/sensitive personal information and any related information as well as its sharing, transfer and/or disclosure to any of the Company's branches, subsidiaries, affiliates, advisors and representatives, industry associations and third parties such as but not limited to outsourced service providers, external auditors, and local and foreign regulatory authorities in relation to any matter including but not limited to those involving anti-money laundering and tax monitoring, review and reporting, statistical and risk analysis, provision of any products, service, or offers made through mail/email/fax/SMS/telephone, customer satisfaction surveys; compliance with court and other lawful orders and requirements. You shall hold the Company free and harmless from any liability that may arise from any transfer, disclosure, processing, collection, use, storage or destruction of said information.

If the policy owner is not a parent, a parent who lives with the child must also sign.

Signature of Policy owner X	Printed Name
Signature of Parent, if not also the policy owner X	Printed Name
Signature of Witness X	Printed Name
Address of Witness (no., street, municipality/city, province, country, zip code)	
Place of Signing	Date of Signing (day/month/year)

Authorization to Obtain Information

Life Insured (Child under age 18)

These statements must be signed by a parent who lives with the child, if not also the policy owner.

You hereby authorize any physician, hospital, clinic, insurance company or other organization, institution, or person that has any personal record of your child to give to the Company any and all information about your child including but not limited to personal and sensitive personal information and other information with reference to your child's health and medical history and any hopitalization, advice, diagnosis, treatment, disease or ailment. This information is required for, and may be sought during evaluation of the risk associated with your child's application for life insurance, administration and continuing service of your child's insurance policy, assessment and payment of insurance claims for living and death benefits, and providing your child with products that cater to your child's needs at any given point in time;

You also authorize the Company to have your child's blood and urine samples analyzed for the purpose of underwriting your application for your child's insurance coverage. The analysis of the blood and urine sample may include, but not limited to, tests where allowed by law, for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of immune disorder or the presence of medication, drugs or nicotine; and

You consent to a personal investigation on your child's, and copy of the authorization granted in these documents shall be as valid as the orginal.

Name of Child	Signature of Parent/Policy Owner X	Date (day/month/year)

Policy Owner

These statements must be signed by the policy owner.

You hereby authorize any physician, hospital, clinic, insurance company or other organization, institution, or person that has any of your personal record to give to the Company any and all information about you including but not limited to personal and sensitive personal information and other information with reference to your health and medical history and any hopitalization, advice, diagnosis, treatment, disease or ailment. This information is required for, and may be sought during evaluation of the risk associated with your application for life insurance, administration and continuing service of your insurance policy, assessment and payment of insurance claims for living and death benefits, and providing you with products that cater to your needs at any given point in time;

You also authorize the Company to have your blood and urine samples analyzed for the purpose of underwriting your application for your insurance coverage. The analysis of the blood and urine sample may include, but not limited to, tests where allowed by law, for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of immune disorder or the presence of medication, drugs or nicotine; and

You consent to a personal investigation on you, and copy of the authorization granted in these documents shall be as valid as the orginal.

Signature in full of Policy Owner X	Printed Name	Date (day/month/year)

Advisor's Report

To be completed by Advisor

About the life insured and policy owner (if the policy includes a waiver of premium benefit)

1. a) Has this application been secured by personal interview with the child's parent/policy owner? ☐ Yes ☐ No If not, how was it secured?	b) If this application is intended for reinstatement, please indicate the reason for lapse.
2. Have you ever heard anything concerning about the policy owner and child's past or present health, medical history, lifestyle or habits or any risk factor that would have an adverse effect on the child's or on the policy owner's insurability? ☐ Yes ☐ No If so, give particulars.	
3. Do the child insured and policy owner appear to be in good health and have a normal appearance? ☐ Yes ☐ No	4. To your knowledge, has the child changed residence during the past 5 years? ☐ Yes ☐ No

Payment information

Is payment included with application? ☐ Yes ☐ No	P.R. No.	P.R. Date (day/month/year)	P.R. Amount

Advisor's information

Name of Advisor	Code	NBO
Signature of Advisor X		Date (day/month/year)

For Company Use only

If form is received through mail by home office staff, indicate

Date Received (day/month/year)	Name of receiving staff	Signature of receiving staff X

If form is received by counter staff, please indicate

Date & Time Received ☐ A.M. ☐ P.M.	Name of receiving staff	Signature of receiving staff X

and answer the following:

a) Was this application secured by personal interview with the child's parent/policy owner? ☐ Yes ☐ No
If so, indicate

Date of Interview (day/month/year)	Name of interviewing staff	Signature of interviewing staff X

b) If this application was not secured by personal interview with the child's parent/policy owner, how was it secured?
Submitted by the child's parent/policy owner's representative? ☐ Yes ☐ No If "No", indicate how it was secured in the box. "Others, specify".

Name of Representative			
Address (no., street, municipality)			
City	Province	Country	Zip Code

Others, specify

Underwriting Department

Medical Information Bureau for Life Insured ☐ Co. ☐ NIL With Reinsurance? ☐ Yes ☐ No	Date Checked (day/month/year)
Searched by: Staff's Signature X	Staff's Printed Name