Living Benefit Claim Form

In this form, ***you*** and ***your*** refer to the life insured and policy owner whose information we are processing or disclosing. ***We***, ***us***, ***our*** and the ***Company*** refer to Sun Life of Canada (Philippines), Inc., a member of Sun Life group of Companies.

As your partner for life, we know that your health is your foremost priority during these times and we would like to help you focus on your recovery by expediting the processing of your claim. Please take note of the following reminders so we can process your claim swiftly.

- Accomplish and submit the completed form and all applicable claim requirements through any of our Client Service Centers or email to phil_claims@sunlife.com. Incomplete information and/or documents will affect the processing of your claim.
- Write legibly using capital letters. Write N/A if question is not applicable.
- Mark the box(es) with a "✓" to indicate your choice(es) then sign the form only when completely filled out.
- Refrain from using third parties to process your claims.

Fraud Warning

P.D. No. 612 or The Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both to any person who makes any fraudulent claim, or fraudulently prepares claim requirements.

This claim is for (*please choose from the list of living benefits below*):

- ☐ Hospitalization
- ☐ Critical Illness (including Sun Fit and Well, Sun LifeAssure, and other similar standalone plans)
- ☐ Female and Maternity Benefits / Female Critical Illness and Maternity Benefits
- ☐ Disability of the Insured or Owner
- ☐ Accidental Dismemberment and/or Disablement
- ☐ Living Benefit Rider (LBR)
- ☐ Group Claims

1 Information about the Life Insured

Name of Life Insured (Last Name, First Name, M.I.)	Policy Number(s)	Date of Birth (month/day/year)
Complete Residence Address (P.O. Box is not acceptable)	Contact Number(s)	E-mail Address

2 Details of Condition

Symptoms experienced and signs noticed	Date symptoms and signs first experienced and noticed
Details of physician who was first consulted for these symptoms and signs (Name of Physician, Contact Number(s), E-mail address)	Date of consultation
Diagnosis (if applicable, please indicate the stage)	
Details of physician who was first consulted for this diagnosis (Name of Physician, Contact Number(s), E-mail address)	Date of diagnosis
Treatment(s) received for this condition	Date of treatment(s)
Surgery/procedure	Date of surgery/procedure

Did you consult other physicians for this condition? ☐ Yes ☐ No If "Yes," please provide the details below:

Name of Physician	Contact Number(s)	E-mail address

Date of Consultation (month/day/year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (month/day/year)	Diagnosis/Remarks	Hospital	Medication Prescribed/Treatment

If the space is insufficient, use the back page of this form.

For disability claim, please provide the following information:

What was your occupation at onset of your present disability?
When did you last work? (month/day/year)
Date you expect to be able to return to work, either full or part time. (month/day/year)

Did you suffer from any other illness, disease, or condition? ☐ Yes ☐ No If "Yes," please provide the details below:

Date of Illness (month/day/year)	Vital Signs (Blood Pressure, Temperature, etc.)	Nature of Complaint or Illness	Date Symptoms First Noticed (month/day/year)	Diagnosis/Remarks	Attending Physician/ Hospital	Medication Prescribed/Treatment

If the space is insufficient, use the back page of this form.

Smoking Habit

Have you ever smoked? ☐ Yes ☐ No If "Yes", please provide details below:
Start date (month/day/year): _____ End date (month/day/year): _____ ☐ Still in the habit

3 Payment Options

Indicate how you would like to receive the benefit proceeds.

☐ **Credit to account** (should be under the name of the Policy Owner, or Life Insured if with Waiver of Benefit)
- ☐ Credit to local bank account
- ☐ Currency conversion (applicable only to a beneficiary residing abroad) – convert to:
  - ☐ US Dollar ☐ Canadian Dollar ☐ Other Currency (please specify) _____
  - subject to availability of the currency in the bank and credit to bank account through overseas transfer

Account Name:	Bank Address:
Account Number:	Routing or Serial Number *:
Bank Name:	Swift Code Number *:

** applicable only to currency conversion*

Important reminders:

1. Ensure that you provide the correct account information. The Company will not be liable if the remittance is credited to the wrong bank account number.
2. Submit proof of bank account e.g. Bank Statement of Account, Certificate of Bank Deposit, First Page of the Bank Passbook, Check, ATM Card or Validated Deposit/Withdrawal Slip showing the bank account number and account name of the beneficiary (submit only one). The bank account number and the account name must appear on the same page and should be readable and clear. Please mask account details and names of other account holders, if any. The Company may require presentation of additional documents to validate submissions.
3. You confirm and agree that:
   a. You will shoulder all bank fees and charges related to the deposit to your bank account;
   b. Deposit of the amount through your designated bank account number or account name fully releases and discharges the Company from any claims or liabilities related thereto; and
   c. You agree to indemnify and hold the Company free and harmless from and against any and all claims, losses, including opportunity loss, damages, or expenses as a result of your credit to account and/or currency conversion request, including any misrepresentation as to the owner of the bank account, and/or failure of your bank or its intermediary to honor the transaction.

☐ **Check** (for Peso policy only) ☐ **RCBC Demand Draft** (for US Dollar policy only)
- ☐ Send through Servicing Advisor at preferred mailing location (automatic if no instruction provided)
- ☐ For pick-up at Sun Life office (specify location): _____
- ☐ For Check – Send by courier/registered mail (specify address): _____
- ☐ For RCBC Demand Draft – For encashment (provide details below):
  - Date of Encashment (month/day/year): _____ RCBC Branch Address: _____

4 Preferred Proof of Transaction

Specify how you would like to receive the forms you signed and proof of transaction:

- ☐ Electronic copy via email to _____
- ☐ Printed copy through my Advisor *(default option for individual insurance if any of the boxes is unmarked)*
- ☐ Printed copy to my mailing address below *(default option for group insurance if any of the boxes is unmarked)*

5 Signatures

By signing, you acknowledged/agree that:

a. To the best of your knowledge and belief that the above answers and those on any attached sheet are complete and true.
b. You authorize any physician, hospital, clinic, insurance company or other organization, institution or person, that has any record of you and/or the life insured, or your and/or the life insured's health, to give to the Company any and all information about you and/or the life insured with reference to your and/or the life insured's health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment.
c. You agree to the processing of your personal and sensitive information for the additional purposes of evaluating your claim and implementing your request/instructions herein in accordance with Sun Life's Privacy Policy available at https://online.sunlife.com.ph/privacy, reaffirm your consent to the processing of your personal data as recorded in your most recent insurance application form, and acknowledge that such consent continues to be in full force and effect.
d. Your rights include the right to be informed, access your data, and rectify errors in your data. For more information about your rights and how we protect your data, you may access our privacy policy at https://online.sunlife.com.ph/privacy. Should you have any concerns in relation to your rights or the processing of your personal and sensitive personal information, you may get in touch with our Data Protection Officer at privacyconcern@sunlife.com.
e. You agree that the claims application shall not be considered complete until the submission of all the required documents.

Signature over Printed Full Name of Life Insured	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Policy Owner (if other than the Life Insured)	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (month/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (moth/day/year)	Place Signed
Signature over Printed Full Name of Irrevocable Beneficiary (for standalone Critical Illness plans)	Date Signed (moth/day/year)	Place Signed
Signature over Printed Full Name of Guardian (if Life Insured/Policyowner is a minor or has mental disability)	Date Signed (month/day/year)	Place Signed