Claimant's Statement (Death Benefit) Form B

Sun Life Financial

Please PRINT clearly.

In this form, *you* and *your* refer to the claimants, 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.

The employment of a third person, on commission or otherwise, for the collection of an approved claim is unnecessary. Settlement is achieved most speedily by direct communication with a local representative of the Company.

All questions must be answered in full.

1 General Information

Name of Insured - now deceased (Last Name, First Name, M.I.)
Policy Number(s)

2 Information regarding the Deceased Insured

If age has not been admitted by the Company, please provide evidence satisfactorily establishing date of birth.

Date of Birth (Month/Day/Year)	Place of Birth
Date of Death (Month/Day/Year)	Place of Death
Occupation at time policy was issued	Occupation at time of death
Complete Residence Address at time policy was issued	
Complete Residence Address at time of death	

State all facts regarding the cause and circumstances of death

Please attach press clippings and the Coroner's report if an inquest was held.

How long was the insured ill?	Give date of first indication of failing health (Month/Day/Year)

Did the insured have any illness previously? ☐ Yes ☐ No If "YES", please provide details

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

Did the insured use intoxicating liquors? ☐ Yes ☐ No	Did the insured use them to excess? ☐ Yes ☐ No
How long before death did the deceased use them to excess?	

Did the insured smoke cigarettes/cigarillos/cigars or consume any other tobacco product?..... ☐ Yes ☐ No

a) If "Yes", fill out appropriate box with number per day

cigarettes	cigars	tobacco	chewing tobacco	other tobacco used

b) If "No", did the life insured ever smoke a cigarette/ cigarillo/ cigar or consumed any other tobacco product in the past?..... ☐ Yes ☐ No

If "Yes", when did the insured stop smoking? month/year

2 Information regarding the Deceased Insured (continued)

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

Names and Addresses of Physicians consulted by the insured within the last 5 years.

Did the insured ever claim any total disability, sickness or accident benefits under any insurance contract within the last 5 years? ☐ Yes ☐ No If "YES", provide details

Did the insured have any other life insurance? ☐ Yes ☐ No If "YES", state company/ies and issue date of policy/ies

3 Information regarding the Claimants and Signatures

This section must be signed by the claimant/s. If a claimant is a minor (under 18 years of age), the guardian for the minor must sign. Additional requirements may be required from the said guardian and advice will be given accordingly.

By signing below, you hereby notify the Company that the person whose life was insured by the Company under the above-numbered policy/ies is dead; and hereby declare that the said person is the one described above and that the foregoing answers and statements made by you are true and correct. You hereby agree that the written statements and affidavits of all the physicians who attended or treated the insured, and all other papers called for by the Company, shall constitute and they are hereby made a part of these Proofs of death, and further, you agree that the furnishing of this form, or any forms supplemental thereto, by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor waiver of any of its rights or defenses.

You expressly waive all provisions of law forbidding any physician or other person who has previously attended or examined the deceased, or any institution in which the deceased received treatment, from disclosing any knowledge or information which was thereby acquired, and you authorize such persons or agencies or government offices to furnish any information in their possession to the Company.

Please complete one box per claimant.

If you are an executor, administrator or guardian, please attach a certified copy of appointment.

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

For Witness to the signature/s of Claimant/s, please sign on the space provided below:

The witness should be a disinterested person and address and contact nos. should be shown on the space provided

Signature of Witness X	Printed Name
Place of Signing	Date of Signing (Month/Day/Year)
Residence Address	
Home Phone/Fax/Business/Cell Phone	

3 Information regarding the Claimants and Signatures (continued)

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

Claimant's Signature X	Date of Birth (Month/Day/Year)
Printed Name (Last Name, First Name, M.I.)	
Residence Address	
Place of Signing	Date of Signing (Month/Day/Year)
Relationship to the Insured	Home Phone/Fax/Business/Cell Phone

For Witness to the signature/s of Claimant/s, please sign on the space provided below:

The witness should be a disinterested person and address and contact nos. should be shown on the space provided

Signature of Witness X	Printed Name
Place of Signing	Date of Signing (Month/Day/Year)
Residence Address	
Home Phone/Fax/Business/Cell Phone	