

Claimant's Statement (Death Benefit) Form A

Please PRINT

In this form, *you* and *your* refer to the claimants, while *we*, *us*, *our* and *the Company* refer to Sun Life Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco 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.

This claim is for Individual Life Group Life

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)	Date of Death (Month/Day/Year)
Cause of Death	Place of Death
Complete Residence Address	

Did the insured have any other life insurance? Yes No If "YES", state companies and issue date of policies.

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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.

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

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

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:

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

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