Sun Life GREPA Financial

Attending Physician's Statement (Death Benefit) Form B

Please **PRINT** clearly

In this form, *you* and *your* refer to the physician who attended to the insured now deceased, 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.

This form is given at the request of the parties making the claim and the Company is not chargeable for any fee therefore.

All questions must be answered in full.

1 General Information

Name of Insured - now deceased (Last Name, First Name, M.I.)	Date of Birth (Month / Day / Year)
Residence Address	Policy Number(s)
Date of Death (Month / Day / Year)	Place of Death
Complete Residence Address	

2 Specific Information Requested

Were you the attending physician during the deceased's last illness? ☐ Yes ☐ No	Were you present when the death occurred? ☐ Yes ☐ No
How long have you been acquainted with the deceased?	

Did you attend to or were you consulted by the deceased before the last illness? ☐ Yes ☐ No
If "YES", please state details of illnesses including dates.

State exact duration of last illness.

What were the first indications of failing health?	When were they first noticed?
First visit in connection with the illness (Month / Day / Year)	Last visit in connection with the illness? (Month / Day / Year)

Have you ever heard or have you any reason to believe that the deceased consulted or was attended by any other physicians or surgeons at any time prior to the first date given in the preceding answer for any illness, ailment or complaint which could in any way be indicative of, allied to or associated with the illness which led to death? ☐ Yes ☐ No
If "YES", please provide details

Immediate Cause of Death	Antecedent Cause of Death	Underlying Cause of Death

Did the deceased suffer from any other associated diseases or condition? ☐ Yes ☐ No
If "YES", please provide details including dates.

2 Specific Information Requested (continued)

Did the deceased have any diseases or illnesses not mentioned above? ☐ Yes ☐ No
If "YES", please provide details including dates.

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

Does the patient 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", has patient ever smoked 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

Was a post-mortem examination or a Coroner's inquest made? ☐ Yes ☐ No
If "YES", please provide details.

Did previous illness, family history, or habits in any way predispose to the cause of death? ☐ Yes ☐ No
If "YES", please provide details.

From physical findings and appearance, what would you judge to be the age of the deceased?

Are you reasonably satisfied that the deceased is the identical person described in the policy of insurance under which claim is now being made? ☐ Yes ☐ No
If "NO", please explain.

3 Physician's Signature

Physician's Signature X		Printed Name
PTR No.	License No.	Field of Specialization
Date of Signing (Month / Day / Year)		Place of Signing (Month / Day / Year)
Address		
Home Phone / Fax / Business / Cell Phone		E-mail Address