

Please PRINT clearly.  
Use BLACK ink.

In the Philippines, this group insurance product is provided by Sun Life Grepa Financial, Inc., a joint venture of Sun Life Financial and the Yuchengco Group of Companies.

In this application, *you* and *your* refer to the person being insured while *we*, *us*, *our* and *the Company* refer to Sun Life Grepa Financial, Inc.

Sun Life Grepa Financial, Inc. is a Covered Institution under Republic Act No. 9160, as amended, otherwise known as the Anti-Money Laundering Act of 2001.

**1 General Information**

For:  New Application  Reinstatement

Serial No. 000000

**Relating to Debtor**

Last Name		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.		<input type="checkbox"/> Miss <input type="checkbox"/> Others, specify	
First Name		<input type="checkbox"/> Single <input type="checkbox"/> Divorced		<input type="checkbox"/> Married <input type="checkbox"/> Separated		<input type="checkbox"/> Widowed	
Middle Name		Date of Birth (Month/Day/Year) _____ Age (last birthday) _____					
Other Legal Names (a.k.a.)		Birthplace		Nationality		<input type="checkbox"/> Filipino <input type="checkbox"/> Others, specify	
TIN		SSS/GSIS No. _____					
Residence Address (no, street, municipality)							
City		Province		Country		Zip Code	
Occupation		Name of Employer		Group Policy No. _____			
Business Address (no, street, municipality)							
City		Province		Country		Zip Code	
Amount of Indebtedness (to be completed by the Debtor)				Term of Contract of Indebtedness			

Please provide complete address; do not use P.O. box.

**Beneficiary**

Primary Beneficiary/ies Name (First Name, MI, Last Name)		Date of Birth (Month/Day/Year)	Relationship to Insured
Contingent Beneficiary in the event of death of all primary beneficiary/ies Name (First Name, MI, Last Name)		Date of Birth (Month/Day/Year)	Relationship to Insured

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

Note: All nominations of beneficiaries are revocable unless otherwise specified.

**2 Declarations and Representations**

- The following questions must be answered by the person being insured.
1. Within the last two (2) years, have any of your applications for insurance been declined, postponed, withdrawn or accepted on a basis other than applied for?  Yes  No
  2. Have you had any symptoms of, sought advice for, or been treated for high blood pressure, stroke, heart trouble, diabetes, cancer or tumour, chest pain, bleeding from the bowel, or blood in your sputum, or has treatment for any of these been recommended by a physician or other practitioner?  Yes  No
  3. Within the last five (5) years, have you been admitted or been advised to be admitted as an in-patient to a hospital or clinic EXCEPT for pregnancy, birth, routine health check-up, gall bladder/kidney stones, colds, flu/influenza, gastroenteritis, upper and lower respiratory tract infections, hepatitis A, appendectomy, tonsillectomy, haemorrhoidectomy, cholecystectomy, and herniotomy?  Yes  No
  4. Do you have any health symptoms or complaints for which a physician has not been consulted or treatment has not been received? For example: persistent fever, unexplained weight loss, loss of appetite, pain or swelling, etc.?  Yes  No

**3 Signature**

By signing below, you declare that to the best of your knowledge and belief, the above answers and those on any attached sheet are complete and true.

You understand and agree that your insurance shall become effective in accordance with the terms and conditions of the Creditor Group Life Policy for which this application is made provided that you are Actively-At-Work on such date.

You also understand and agree that while insured under the Creditor Group Life Policy, the Amount of Insurance in force at the time of your death shall be used to discharge you of your Outstanding Indebtedness to the Creditor.

The excess, if any, of the Amount of Insurance over your Outstanding Indebtedness shall be made payable to your beneficiaries.

Place of Signing	Date (Month/Day/Year)
Your Signature X	Printed Name
Witness X	Name of Witness

This section must be signed by the person being insured.