Part 1 - Health Insurance Application

Policy Number

Application Number

Advisor's Name

Section 1

Proposed Insureds

Name: Last	First	Middle

Date of Birth (Day / Month / Year)	Age	Place of Birth	Maiden Name (if applicable)	Alias	Height	Weight

Gender	Marital Status	Country of Residence	Status
			☐ Citizen ☐ Resident

National Identification Number	(or) Passport Number	(or) Driver's Licence Number	Nationality

Occupation	Former Occupation	Current Employer

Nature of Duties	Length Of Employment

Business Address

Home Address	How Long?

Postal Address

Telephone Numbers

Home	Work	Cell	Email Address

Do you wish to receive email or text messages from Sagicor Life Inc? Yes ☐ No

Section 2

Proposed Insureds Names and Data on Family Members

	FAMILY MEMBER'S NAME List of all family member's (Last) (First) (Middle) (Maiden)	Birthdate DD/MM/YY	Birthplace	Gender	Height	Weight
Spouse						
Child						
Child						
Child						
Child						
Child						
Occupation of Spouse						

Advisor's Comments

Section 3

Policy Number	Application Number

QUESTIONS TO BE ANSWERED CONCERNING THE PROPOSED INSUREDS NAMED IN SECTION 1 & 2 IF ANY OF THESE QUESTIONS ARE ANSWERED "YES". GIVE COMPLETE DETAILS	PROPOSED INSURED			DEPENDENTS		
	Yes	No	Details	Yes	No	Details
A. Have you or do you intend to engage in hand gliding, parachuting, vehicle racing, skin or scuba diving or any other hazardous sport or hobby?	☐	☐		☐	☐	
B. Have you or do you intend to fly other than as a passenger? (If yes, complete the attached aviation questionnaire)	☐	☐		☐	☐	
C. Will this application replace insurance with this or any other company?	☐	☐		☐	☐	
D. Do you have any other applications pending or contemplated with this or any other company? (If yes, name of company and amount applied for).	☐	☐		☐	☐	
E. Have you ever applied for insurance which was declined, postponed, not taken, modified or rated in any way? (If yes, name of company, amount applied for and rating received).	☐	☐		☐	☐	
F. Have you had any driving convictions or suspensions in the last 3 years, or past or pending court matters?	☐	☐		☐	☐	
G. Do you smoke cigarettes, marijuana, cigarillos, cigars or a pipe? (If yes, indicate how many per day of each).	☐	☐		☐	☐	
H. Have you ever been a cigarette or marijuana smoker in the past? (If yes, indicate how many cigarettes per day, and when and why you quit).	☐	☐		☐	☐	
I. Have you ever been told to quit cigarette smoking for medical reasons? (Give details, and names of physicians).	☐	☐		☐	☐	

Section 4 – Family Medical History or Proposed Insureds

(A) Have your parents, brothers or sisters ever had diabetes, high blood pressure, heart or kidney disease, cancer or mental illness, stroke, multiple sclerosis, Alzheimer's disease, or any other hereditary disease? Please state age of onset of disease. ☐ YES ☐ NO

Family History		Age	Give Details of Present Health Any Heart Disease, Diabetes?		Age	Cause of Death
Father	LIVING			DECEASED		
Mother						
Brothers						
Sisters						

(B) SPOUSE

Have your parents, brothers or sisters ever had diabetes, high blood pressure, heart or kidney disease, cancer or mental illness stroke, multiple sclerosis, Alzheimer's disease, or any other hereditary disease? Please state age of onset of disease. ☐ YES ☐ NO

Family History		Age	Give Details of Present Health Any Heart Disease, Diabetes?		Age	Cause of Death
Father	LIVING			DECEASED		
Mother						
Brothers						
Sisters						

Policy Number	Application Number

Section 5 – Data on Proposed Insureds

INFORMATION CONCERNING ALL INSUREDS

		YES	NO
1.	To the best of your knowledge and belief, have you or your listed family members:	YES	NO
	a. Ever used heroin, morphine, or other narcotic drugs, LSD, Marijuana or other psychotherapeutic drugs?	☐	☐
	b. Ever been arrested or received treatment for drug or alcohol usage?	☐	☐
	c. Ever consulted, been treated or examined by a physician, psychiatrist or psychologist?	☐	☐
	d. Ever been advised to have a test for diagnostic purposes, medical treatment, hospitalization or surgery?	☐	☐
	e. Undergone any type of x-ray exam, lab test, special investigation or surgery within the last 3 years?	☐	☐
2.	Are you or your listed family members currently under any treatment?	☐	☐
3.	Of the proposed insureds, is any presently residing outside his/her country of residence? Give name, reason and present address	☐	☐
4.	Do you drink alcoholic beverages? If so indicate amount and frequency.	☐	☐

	Stout/Beer (bottle)	Wine (glass)	Liquor (# drinks)
Daily:	__________	___________	______________
Weekly:	__________	___________	_______________

DETAILS OF "YES" ANSWERS TO QUESTION 1- 3

Name of Person and Questions No.	Condition & Complications (if surgery done, so state)	Onset Mth./Yr	Duration	Name & Address of Physicians & Hospital

Section 6 – Existing and Pending Insurance – Health, Disability and Critical Illness

Insurance in force and Pending with All Companies on Proposed Insureds (If none, insert "NONE")

Name of Insured/Applicant	Company	Type of Coverage	Face Amount	Accidental Death	Critical Illness Cover	Year Issued

Section 7 – Policy Plan and Particulars

☐ Medical ☐ Dental ☐ Vision

Currency____

Deductible ☐ $0 ☐$500 ☐$1,000 ☐$2,000

Major Medical Maximum ☐$250,000 ☐$500,000 ☐$1,000,000

Policy Number | Application Number

Policy Number	Application Number

Payment Method

☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

☐ Direct Debit ☐ Salary Deduction ☐ Government ☐ Over the Counter ☐ Online

Modal Premium [ ] Amount Paid with Application [ ]

Section 8 - Part 2 of Application

1. NAME AND ADDRESS OF PERSONAL PHYSICIAN OR SPECIALIST (OF YOURSELF OR ANY FAMILY MEMBER TO BE INSURED:-

____

DATE OF LAST VISIT: _________________ REASON & RESULTS: ____

2. NAME AND ADDRESS OF DENTIST (OF YOURSELF OR ANY FAMILY MEMBER TO BE INSURED):-

____

DATE OF LAST VISIT: __________________ REASON & RESULTS: ____

3. NAME AND ADDRESS OF ALL OTHER DOCTORS SEEN (BY YOURSELF OR ANY FAMILY MEMBER TO BE INSURED) WITHIN THE LAST 5 YEARS:-

____

DATE OF LAST VISIT: __________________ REASON & RESULTS: ____

4. **ADDITIONAL INFORMATION CONCERNING PROPOSED INSURED** To the best of your knowledge and belief, does any person proposed for insurance have or has he/she ever had, or been treated, or even been told that, he/she has or had any of the following diseases or disorders:

	Yes	No		Yes	No
a. Asthma, Emphysema, Bronchitis, or any disease or disorder of the lungs or respiratory system?	☐	☐	h. Eyes, ears, nose, throat, or endocrine system, including thyroid disorders?	☐	☐
b. High blood pressure, chest pain, heart attack, shortness of breath, rheumatic fever, or any disease or disorder of the heart or circulatory system, including varicose veins?	☐	☐	i. Allergies, anemia or other blood disorder?	☐	☐
c. Fainting spells, epilepsy, convulsions, head injury, migraine, stroke or any disease or disorder of the brain or nervous system, including tremor, numbness and dizziness?	☐	☐	j. Any other disease, injury, operation, deformity or disorder, including infectious diseases?	☐	☐
d. Albumin, or blood in urine, diabetes or any disease or disorder of the kidneys, bladder or prostate gland, or veneral diseases?	☐	☐	k. Any disease or disorder of the reproductive system, including endometriosis, fibroids, ovarian cysts and breast disease	☐	☐
e. Cancer, tumor, cysts or abnormal growths, any skin disorder?	☐	☐	l. Positive HIV test?	☐	☐
f. Any disease or disorder of the stomach, colon, liver, pancreas, gall bladder or any other digestive disorder?	☐	☐	m. Females: Are you presently pregnant? Expected delivery date	☐	☐
g. Any disease or disorder of the muscle, or joints, including the vertebral column and the back, including paralysis and arthritis?	☐	☐			

DETAILS OF "YES" ANSWERS TO QUESTION 4

Name of Person and Question No	Condition & Complications (If Surgery done, so state)	Onset Mo/Yr	Duration	Name & Address of Physicians & Hospitals

Policy Number	Application Number

PRE-EXISTING CONDITIONS ARE NOT COVERED UNLESS SPECIFIED IN THE POLICY OR ANY RIDER THERETO,

CONSENT AND AUTHORISATION: I/We consent to undergo an Electrocardiogram, X-ray, Blood tests (for diabetes, AIDS, etc.) or any other tests considered necessary by the Insurer and/or its Reinsurers. I/We authorize any licensed Physician, Medical Practitioner, Hospital, Clinic or any other medically related facility, Insurance Company, Medical Information Bureau or any other organization, institution or person that has or may in the future have any records or knowledge of my/our health or the health of any minor dependant named in this application, to release any such information to the Insurer and its Reinsurers. I/We authorize the Insurer and its Reinsurers to obtain reports containing personal information and financial information relating to this application and to disclose such information to institutions and authorities that are legally entitled to receive it and to other insurers. I/We further authorize the disclosure of such information to any agency engaged by the Insurer to collect and transmit such information. A photocopy of this authorization shall be as valid as the original.

By checking the box below, I/we consent to the employees or advisor of the Insurer or affiliated companies in the Sagicor Group contacting the undersigned and any Covered Dependant aged 18 or older from time to time concerning services provided by the Insurer or its affiliates.

DECLARATION: I/We the undersigned do hereby declare that the foregoing statements and answers are complete, true and correctly recorded and agree to be bound by all statements and answers made or to be made in this application including any supplement hereto. This application including any supplement hereto and any policy issued in consequence hereof shall constitute the entire contract. No advisor is authorized to makeor modify any contract, to waive any of the Insurer's rights or requirements or to bind Sagicor Life Inc. (the "Insurer") by making or receiving any promise, representation or information, unless the same be in writing, submitted to the Insurer and made a part of such contract. I/We agree that this declaration shall be the basis of the contract between the Insured and Sagicor Life Inc. and that, if any fraudulent or material untrue statement has been made, or material information withheld, including failure to advise the Insurer of a change in the health status or occupation of the undersigned prior to the issue of a policy on the basis of this application, such policy shall be absolutely null and void. I/We further agree that the insurance applied for shall not become effective until the policy is delivered to and accepted by the Insured and the entire first premium has been paid while all the answers in this application and any supplement hereto continue to be complete and true answers; and that the Insurer is authorized to amend any portion of this application by making an appropriate notation of any correction or amendment to this application for insurance and the acceptance of any policy issued by reason of this application shall constitute ratification of any such change.

SIGNED AT ________________________________ **DATE**____

INSURED SIGNATURE _______________________________ **WITNESS**______________________________

SPOUSE SIGNATURE _______________________________ **WITNESS**________________________________

Policy Number	Application Number

ADVISOR'S REPORT

A. How long have you known the Proposed Insured? Years ________months __________

B. Are you related to the Proposed Insured? ☐ Yes ☐ No Relationship ___________________________

C. Are you aware of any information concerning health, character, reputation, living environment, bankruptcy, questionable associates, financial difficulties, etc of the Proposed Insured(s)? ☐ Yes ☐ No (If yes, please give details)
____

D. Did you personally interview the Proposed Insured(s)? ☐ Yes ☐ No (If No, please give details)
____

E. If 3rd party, did you see the Proposed Insured(s) at time of completion of this application? ☐ Yes ☐ No ☐ N/A
(If No state why)____

F. Was any other person(s) present to answer questions? ☐ Yes ☐ No (If yes, please give details)
____

G. Is the Proposed Insured blind or unable to read and/or write? ☐Yes ☐ No (If yes, Attestation form to be completed).

H. Is the Proposed Insured and /or applicant a Politically Exposed person? ☐ Yes ☐ No (If yes, Politically Exposed form to be completed).

I. Has the applicant purchased any Life, Health, Critical Illness or Personal Accident coverage with Sagicor within the last12 months? ☐ Yes ☐ No (If yes, state policy number(s) and type(s) of coverage.

Policy Number(s)	Type(s) of Coverage

J. Is a valid Photo ID attached? ☐ Yes ☐ No 2. Is valid proof of address document attached? ☐ Yes ☐ No

Additional remarks: ____

The above answers are true to the best of my knowledge and belief.

_______________________ Advisor's Signature
_______________________ Advisor's Number
_______________________ Date

_______________________ Agency/Branch Manager's Signature
_______________________ Date

FOR ADMINISTRATIVE USE ONLY		
ADMIN. REPORT		
1. Have all questions been answered?	Yes ☐	No ☐
2. Has the full premium been paid?	Yes ☐	No ☐
3. Have all required questionnaires and forms been completed and attached to this application?	Yes ☐	No ☐
4. Have the medical requirements been met?	Yes ☐	No ☐

Admin. Signature: ___________________ Print Name: ______________________________ Date: __________________