Sagicor

Part 2 - Application for Life Insurance

Policy No. _____

NON-MEDICAL QUESTIONNAIRE

1. Full Name of Child Insured (Print)	2. a. Birth date	b. Age

3. a. Is the child below normal school grade for age? Yes ☐ ☐No

b. Has the child lost more than 2 consecutive weeks from school in the past year due to sickness or injury? Yes ☐ ☐No

c. Is the child's family subject to any chronic disorder? Yes ☐ ☐No

d. Has the normal immunization programme been carried out? Yes ☐ ☐No

Please provide any additional information that you feel is important or if the answer to any of question "3a" thru "d" is Yes.

_____

_____

4. Does the child have a personal physician? Yes ☐ ☐No

Name and address of physician _____

Date physician last consulted _____

Disorder/Diagnosis _____

Results _____

Treatment given _____

Medication prescribed _____

5. Weight at birth _____lbs/Kg. Was the child's birth premature? ☐Yes ☐No If Yes, please amplify: _____

6. Height _____ft/m ____in/cm Weight _____lbs/Kg.

Has weight changed in the past year?
If Yes, Gain _____ lbs/Kg. Loss _____ lbs/Kg.

☐ Average growth ☐ Increased exercise
☐ Diet ☐ Change in eating habits
☐ Illness ☐ Unknown
☐ Other _____

7. If the answer to questions 1 through 10 is "Yes", underline item and explain fully under #11".

Has the child ever suffered from or has a doctor been consulted about any signs or symptoms relating to:

1. Brain, nervous, spinal trouble or fits? Yes ☐ No ☐
2. Nose, throat or lung trouble? Yes ☐ No ☐
3. Heart or blood vessels, sickle cell disease or other blood disorder? Yes ☐ No ☐
4. Digestive or intestinal trouble? Yes ☐ No ☐
5. Kidney or bladder trouble? Yes ☐ No ☐
6. Rheumatism, rheumatic fever or any disease of bones or joints? Yes ☐ No ☐
7. Having cancer, tumor, leukemia or mental disorder? Yes ☐ No ☐
8. Eye, ear or speech trouble? Yes ☐ No ☐
9. Any operation, injury, gland trouble, allergy, diabetes or any other illness not mentioned above? Yes ☐ No ☐
10. Has the child ever had an X-ray, blood or other special examination, or been hospitalized? Yes ☐ No ☐
11. Amplify giving dates, treatment, results, names and addresses of Doctors, Hospitals etc

_____

_____

_____

_____

_____

Family History	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

The answers above are given by me and are, to the best of my knowledge and belief, complete and true.

Dated this_____day of_____, Year_____

_____ Witness

_____ Signature of Parent/Guardian

Sagicor

Part 2 - Application for Life Insurance

Application No. | Policy No.

NON-MEDICAL QUESTIONNAIRE

1. Full Name of Proposed Insured (Print)	Maiden Name (If Applicable)	2. a. Birth date	b. Age

3. a. Name and address of your personal Physician?	Date of last visit	Reason and Results	Treatment/Medication Prescribed

	YES	NO
4. Have you ever been treated for, tested for, or even had any known indication of:		
a. **Disorder of the eyes, ears, nose or throat?**	☐	☐
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis, transient ischemic attack, epilepsy, depression, multiple sclerosis, Alzheimers, Parkinsons, tremor, motor neuron disease, or stroke; mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, turberculosis, sleep apnea or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, angina, irregular pulse, cholesterol elevation, abnormal ECG, heart murmur, heart attack or other disorder of the heart or blood vessels or circulatory system?	☐	☐
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, intestinal polyps, GERD, crohns, diarrhoea, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; sexually transmitted disease including Hepatitis B; stone, cysts or other disorder of the kidney, bladder, prostate or reproduction organs	☐	☐
g. Diabetes; thyroid, pancreas, glandular disorder, or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, lupus, fibromyalgia, chronic fatigue or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
i. Deformity, lameness, loss of limb or amputation?	☐	☐
j. AIDS (Acquired Immunodeficiency Syndrome), ARC (AIDS-Related Complex), HIV positive test, or any immunological disorder?	☐	☐
k. Sickle cell disease or trait, other anemia, allergies or other blood disorders?	☐	☐
l. Cancer, tumor, cyst, polyp, lump, discharge or any other malignancy?	☐	☐
m. Any breast disorder, including swelling, cysts, unusual changes, lesions, discharge **or abnormal mammogram or ultrasound?**	☐	☐
n. Do you have any tattoos or multiple body piercings?	☐	☐
5. Within the last 12 months, have you used any product containing marijuana, tobacco, **cigar, pipe, cotinine, including tobacco cessation products? If "Yes", what product did you** consume, how much and how frequently?	☐	☐
6. Does the Proposed Insured currently drink alcoholic beverages? Stout/Beer (bottle) Wine (glass) Liquor (# drinks) Daily: _____ _____ _____ Weekly: _____ _____ _____	☐	☐
7. Have you used:		
a. Barbiturates, sedatives or tranquilizers habitually?	☐	☐
b. L.S.D., marijuana, cocaine, stimulants or other amphetamine?	☐	☐
c. Heroin, morphine or other narcotic drug?	☐	☐
8. Have you within the past 10 years had a blood transfusion?	☐	☐
9. In the past 10 years, have you been treated for alcoholism or any drug habit?	☐	☐
10. Are you now under observation or taking treatment, including alternative therapy, herbal or **special diet?**	☐	☐
11. Have you had any change in weight in the past year? If yes, how much?	☐	☐
12. Other than above, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?	☐	☐
b. Had a checkup, consultation, illness, injury, operation or same day surgery?	☐	☐
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?	☐	☐
d. Had electrocardiogram, X-ray, colonoscopy, ultrasound, PSA or other diagnostic test?	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was NOT completed?	☐	☐
13. a. Have you suffered or are you suffering from any long-lasting chronic illness?	☐	☐
b. Are you aware of any symptoms or complaints for which you have not yet consulted a doctor?	☐	☐
14. a. Have any of your immediate family (including spouse, brothers or sisters) ever been treated for: tuberculosis, diabetes, cancer, growth or other malignancy, high blood pressure, stroke, heart **or polycystic kidney disease, multiple sclerosis, alzheimer's disease or any mental or nervous disorder, AIDS, Parkinson's, Lou Gehrig's disease, motor neuron disease sickle cell disease, Huntington's chorea, or any inherited disease?**	☐	☐

16. a. Height ____Ft. ___Inches _____ Cm.

16. b. Weight _____ Lbs. _____ Kg.

Details of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities).

14. b. **If "Yes", state family member and age of onset.**

15.

Family History	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Wife (Husband)				

17. Females Only:
a. Are you now pregnant? ☐ Yes ☐ No
b. How far advanced? _____ months
c. How many children? ___ Pregnancies? ___
d. Any miscarriages? ☐ Yes ☐ No
e. Have you ever had or been told you had any disorder of the female reproductive organ, pelvis breast or menstruation? ☐ Yes ☐ No
f. Have you ever done or was asked to do a pap smear, mammogram, colposcopy, breast or pelvis ultrasound? ☐ Yes ☐ No (If yes, state date, reason and results)

I hereby declare that the foregoing answers are true and they shall be held to form part of the proposal for insurance on my life. Dated this_____day of_____, 20_____.

Witness

Signature of Proposed Insured (Applicant if Proposed Insured is under 15)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institute or person that has any records or knowledge of me or my health, to give any such information to Sagicor Life Inc. A photographic copy of this authorization shall be as valid as the original. I also authorize Sagicor Life Inc to release to my health care professional any medical information obtained for this insurance application including the results of any blood or urine tests or drug screening tests for purposes of revealing findings which might require further investigation or treatment or for purposes of explaining an underwriting decision.

Date

Signature of Proposed Insured (Applicant if Proposed Insured is under 15)