# GROUP HEALTH STATEMENT

For Child Dependants aged 14 or younger.

A new form must be completed by the Employee for each Dependant.
Please answer all questions. Please give complete details of all "Yes" answers in questions 1-11. Please give complete details if your answer is "No" to question 12. Please state diagnoses, results, dates, and names of all attending physicians and medical facilities in table on the next page. Any changes or corrections MUST be initialled.

| Company Name / Stamp | Group Policy No. | Certificate No. |
|---|---|---|
| | | |

| Employee's Last Name | Employee's First Name | Maiden Name (if applicable) | Employee's Address |
|---|---|---|---|
| | | | |

| Child Dependant's Last Name | | Child Dependant's First Name | Relationship to Employee |
|---|---|---|---|
| Child's Date of Birth DD / MM / YYYY | Age | Birthplace | Country of Birth |
| | | | |

| | N/A | Yes | No |
|---|---|---|---|
| 1. Has the child had any condition for which medical consultation, investigation, operation or treatment is contemplated or has been advised? | | ☐ | ☐ |
| 2. Is the child below normal school grade for age? | ☐ | ☐ | ☐ |
| 3. Has the child lost more than 2 consecutive weeks from school in the past year due to sickness or injury | ☐ | ☐ | ☐ |
| 4. Has the normal immunization programme been carried out? | | ☐ | ☐ |
| 5. If the child is less than 2 years of age, were there any problems during pregnancy or first year of life? | ☐ | ☐ | ☐ |
| 6. Does the child have a personal physician or was seen by any doctor, clinic, or institution? | | ☐ | ☐ |

If "Yes", please answer the following questions:

| Name of Personal Physician / Doctor last visited | Physician's Address | Physician's Office Phone |
|---|---|---|
| Date last consulted | Reason for consultation<br>☐ Regular Check Up ☐ Immunization ☐ Cold/Flu<br>☐ Other | |
| If "Other", please provide the following details | Disorder/Diagnosis | |
| | Results | |
| | Treatment Given | |
| | Medication Prescribed | |

7. Was the child's birth premature? ☐ ☐

   Weight at birth: _____ Lbs _____ Oz / _____ Kgs

If "Yes", please provide additional details below:

8. Child's details:

   (a) Height: _____ Ft _____ In / _____ m _____ cm

   (b) Weight: _____ Lbs _____ Oz / _____ Kgs

   (c) Has the weight changed in the past year? ☐ ☐

   If "Yes", Gain: _____ Lbs / _____ Kgs  Loss: _____ Lbs / _____ Kgs

   Reason:
   ☐ Average Growth ☐ Increased Exercise ☐ Diet ☐ Change in Eating Habits ☐ Illness ☐ Unknown ☐ Other (Please fill in below)

9. To the best of your knowledge has the child been investigated or diagnosed for treatment or shown any signs or symptoms relating to:

   (a) Brain, nervous system, down syndrome, mental disorder, fits, or epilepsy? ☐ ☐

   (b) Nose, throat, allergies, asthma or other lung disease? ☐ ☐

   (c) Heart or blood vessels, chest pain, sickle cell disease, anaemia, or other blood disorder? ☐ ☐

   (d) Digestive, stomach, intestinal, jaundice or liver disorder? ☐ ☐

   (e) Kidney or bladder disorder? ☐ ☐

   (f) Arthritis, rheumatism, lupus, rheumatic fever or any disease of bones or joints? ☐ ☐

   (g) Having cancer, tumour, leukaemia, enlargement of lymph nodes (glands) chronic diarrhoea, unusual skin lesions, or unexplained infections? ☐ ☐

   (h) Eye, ear, or speech trouble? ☐ ☐

   (i) Any congenital or acquired abnormalities, hereditary disorders including haemoglobinopathies, or AIDS? ☐ ☐

   (j) Diabetes, sugar, albumin, blood or pus in urine, thyroid, pancreas, or other endocrine disorder? ☐ ☐

| | | Yes | No |
|---|---|---|---|
| (k) | Has the child in the last five years, had any operation, consulted a physician, or been examined or treated at a hospital or other medical facility, for any illness, or injury or physical abuse? | ☐ | ☐ |
| (l) | Has the child received any blood transfusion or is under observation or treatment by a physician at present? | ☐ | ☐ |
| (m) | Hernia, disorder or deformity of limbs, muscles or bones including spine, back or joints? | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| 10. | Has the child ever had | (a) X-Ray, Ultrasound or Scan | ☐ | ☐ |
| | | (b) An Electrocardiogram | ☐ | ☐ |
| | | (c) Blood or Other Special Tests | ☐ | ☐ |
| | | (d) Any Hospitalization | ☐ | ☐ |
| 11. | Has the child had any physical impairments, or illnesses not covered in questions 1-10 above? | | ☐ | ☐ |
| 12. | Is the child in first class health to the best of your knowledge and belief? If No, please provide full details below. | | ☐ | ☐ |

Please give FULL DETAILS for all “Yes” answers for question 1-11 or any “No” answer to question 12, stating diagnoses, results, dates, and names of all attending physicians and medical facilities in table below.

| Question # | Name of Child | Date / Duration | Illness/ Disability/ Diagnosis | Treatment / Result | Names and Full Addresses of Doctors and Hospitals and supply Medical Reports where applicable |
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DECLARATION: I have read all the recorded answers included above and declare that, to the best of my knowledge and belief, they are full, complete and true, as of this date. Sagicor Life Inc / Sagicor Life (Eastern Caribbean) Inc/Sagicor Life Insurance Trinidad & Tobago Limited must be notified if there is a symptom or diagnosis of any condition between this application date, the acceptance of the risk and effective date coverage. I am aware that if any untrue statement has been made or information necessary to be made known to the Insurer has been withheld, the benefits applied for shall be absolutely null and void.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution, person or medical information bureau that has or may hereafter any records or knowledge of the above-named employee / dependant or their health, to give Sagicor Life Inc / Sagicor Life (Eastern Caribbean) Inc/ Sagicor Life Insurance Trinidad & Tobago Limited any such information.

Employee Signature _____ Date _____

Witness Name (Block Letters) _____ Witness Signature _____