GROUP HEALTH STATEMENT

For Employees and Dependants aged 15 or older.

A separate form must be completed by the Employee or Dependant.
Please answer all questions. Please give complete details of all "Yes" answers in questions 1-5, and 9-11.
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

Name of Personal Physician or Doctor last visited	Physician's Address	Physician's Office Phone

Date of Last Visit	Reason and Results	Treatment/Medication Prescribed

Complete this section if form is being completed by Dependant

Dependant's Last Name	Dependant's First Name	Maiden Name (if applicable)	Relationship to Employee

Details of Employee or Dependant

Birth date DD / MM / YYYY	Birthplace Country	Height Cm. Ft. Ins	Weight Kilos Lbs	Weight Change in Past Year ☐Gain ☐Loss ☐None Kilos Lbs

		Yes	No
1.	Have you		
	(a) ever applied for or received benefits, compensation or pension because of sickness or injury?	☐	☐
	(b) been absent from work because of sickness or injury during the last six months?	☐	☐
	(c) undergone treatment for alcoholism or drug habit?	☐	☐
	(d) any condition for which medical treatment or consultation is contemplated or has been advised?	☐	☐
2.	Have you ever consulted a physician been treated for, or ever had any known indication of (*underline illness if "Yes"*):		
	(a) Disorder of Eyes, Ears, Nose or Throat?	☐	☐
	(b) Dizziness, Fainting, Convulsions, Headaches, Speech Defect, Paralysis, Stroke or Transient Ischemic Attack (T.I.A), Epilepsy, Depression, Alzheimer's, Parkinson's, Tremor, Motor Neuron Disease, Multiple Sclerosis, Coma, Mental or Nervous Disorder?	☐	☐
	(c) Shortness of Breath, Persistent Hoarseness or Cough, Blood Spitting, Bronchitis, Pleurisy, Asthma, Emphysema, Tuberculosis, Sleep Apnoea or Chronic Respiratory Disorder?	☐	☐
	(d) Chest Pain, Palpitation, High Blood Pressure, Rheumatic Fever, Angina, Irregular Pulse, Elevated Cholesterol, Abnormal ECG, Heart Murmur, Heart Attack or Other Disorders of the Heart or Blood Vessels or Circulatory System?	☐	☐
	(e) Jaundice, Intestinal Bleeding, Ulcer, Hernia, Appendicitis, Colitis, Diverticulitis, Haemorrhoids, Recurrent Indigestion, Intestinal Polyps, GERD, Crohn's, Diarrhoea or Other Disorders of the Stomach, Intestines, Liver or Gallbladder, Colon Polyps, Hepatitis?	☐	☐
	(f) Sugar, Albumin, Blood or Pus in Urine, Sexually Transmitted Disease including Hepatitis B; Stone, Cysts or Other Disorders 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, Physical Impairment, Lameness, Back or Limb disorder or Amputation?	☐	☐
	(j) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or any immunological disorder, Positive HIV test?	☐	☐
	(k) Sickle Cell Disease or Trait, Other Anaemia, Allergies or Other Blood Disorders?	☐	☐
	(l) Cancer, Tumour, Cyst, Polyp, Lump, Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, Unusual Skin Lesions, Discharge, Unexplained Infections, 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?	☐	☐
3.	Have you ever used or dealt in Barbiturates, Narcotics or other Drugs, Excitants or Hallucinogens, Marijuana, except as Medication prescribed by a Physician? (*If "Yes", kindly complete a Drug Usage Questionnaire*)	☐	☐
4.	Are you now under observation or taking treatment including alternative therapy, herbal or special diet?	☐	☐
5.	Other than the above, have you within the past 5 years		
	(a) Had any Mental or Physical Disorder not listed above?	☐	☐
	(b) Had a Check-up, Consultation, Illness, Injury, Operation or Same Day Surgery?	☐	☐
	(c) Been a patient in a Hospital, Clinic, Sanatorium or other Medical Facility?	☐	☐
	(d) Had an ECG, Xray, Colonoscopy, Ultrasound, PSA or other Diagnostic Tests?	☐	☐
	(e) Been advised to have any Diagnostic Test, Hospitalization or Surgery which was NOT completed?	☐	☐
6.	Have you ever used alcoholic beverages? (*If yes, please give details in the table below*)	☐	☐

	Stout/Beer (# of bottles)	Wine (# of glasses)	Liquor (# of drinks)
Daily			
Weekly			
Monthly			

7.	Within the last 12 months, have you used any product containing tobacco, cigar, pipe, nicotine, including tobacco cessation products? (*If "Yes", kindly complete a Smoking Questionnaire*)	☐	☐

		Yes	No
8.	Have you done any flying as a pilot within the last two years? (*If "Yes", kindly complete an Aviation Questionnaire.*)	☐	☐
9.	Have you had a request for Life or Health Insurance declined, postponed, rated or restricted in any way?	☐	☐
10.	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐	☐
11.	FEMALES ONLY: (*Please answer all questions.*)		
	(a) Are you now pregnant?	☐	☐
	How far advanced? _____ weeks. Expected Date of Delivery (DD/MM/YY) _____		
	(b) Was your last pregnancy normal?	☐	☐
	(c) How many children do you have? _____ How many pregnancies? _____ How many miscarriages? _____		
	(d) Have you ever done or was asked to do a Pap Smear, Mammogram, Colposcopy, Breast or Pelvic Ultrasound?	☐	☐
	(e) Have you ever been told you had any Disorder of the Female Reproductive Organ, Pregnancy, Pelvic area, Breast or Menstruation?	☐	☐
12.	To the best of your knowledge and belief, are you now in good health and free from any mental, physical deformity or defects?	☐	☐
13.	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?	☐	☐

If "Yes", please state family member and age of onset. _____

14. Family History

	Living		Dead	
Member	**Age**	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				
Wife/Husband				

15.	If this form is for a dependant spouse, does the spouse have a different last name than the employee? If yes, please include a copy of the marriage certificate or declaration of common-law marriage.	☐	☐
16.	If this form is for a dependent child:		
	(a) Does the child have a different last name than the employee? (*If yes, please include a copy of the child's birth certificate.*)	☐	☐
	(b) Is the child below normal school grade for age?	☐	☐
	(c) Is the child aged 19 or older? (*If yes, please include a letter from the school stating that the child is enrolled in full time study.*)	☐	☐

Please give complete details for all "Yes" answers in questions 1-5 and 9-11 above. Please give complete details if your answer is "No" to question 12 above. Please state diagnoses, results, dates, and names of all attending physicians and medical facilities in table below.

Question #	Date / Duration	Illness/ Disability/ Diagnosis	Treatment / Result	Names and Full Addresses of Doctors and Hospitals and supply copy of Medical Reports where applicable

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 of 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 have any records or knowledge of the above-named employee / dependant, 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) and Signature Dependant Name (Block Letters) and Signature