Sagicor

GROUP HEALTH STATEMENT

A NEW FORM MUST BE COMPLETED BY THE EMPLOYEE & EACH DEPENDENT.

All Questions must be answered in full for application to be reviewed.

For Questions 1-5, 8-12 & 14, please give FULL DETAILS for all "Yes" answers, stating diagnoses, results, dates, and names of all attending physicians and medical facilities in table on the next page. All changes and corrections MUST be initialled.

COMPANY NAME:			**Group Policy #:**
Employee's Name:	**Dependent's Name (*if applicable*):**		**Where Applicant is a married woman state Maiden Name:**
Birth date: DD/ MM / YYYY	**Age:**	**Height:** _____ **Ft.** _____ **Inches**	**Weight:** _____ **Lbs**	**Weight Change in the Past 12 months** ☐ **No change** ☐ **Gain** _____ **Lbs** ☐ **Loss** _____ **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 ***(If yes, underline illness)***:		
A.	Disorder of Eyes, Ears, Nose or Throat, Diabetes, Thyroid or other Endocrine Disorders?	☐	☐
B.	Dizziness, Fainting, Convulsions, Headaches, Speech Defect, Paralysis, Stroke or Transient Ischemic Attack (T.I.A.) Multiple Sclerosis, Coma, Mental or Nervous Disorder?	☐	☐
C.	Shortness of Breath, Persistent Hoarseness or Cough, Blood Spitting, Bronchitis, Pleurisy, Asthma, Emphysema, Tuberculosis or Chronic Respiratory Disorder?	☐	☐
D.	Chest Pains, Palpitation, High Blood Pressure, Rheumatic Fever, Heart Murmur, Heart Attack or other Disorder of the Heart or Blood Vessels, Including: Abnormal ECG, Elevated Cholesterol, Angina, Peripheral Vascular disease?	☐	☐
E.	Jaundice, Intestinal Bleeding, Ulcer, Hernia, Appendicitis, Colitis, Diverticulitis, Hemorrhoids, Recurrent Indigestion or other Disorder of the Stomach, Intestines, Liver or Gallbladder, Colon Polyps, Hepatitis?	☐	☐
F.	Sugar, Albumin, Blood or Pus in Urine, Venereal Disease, Stone or other Disorder of Kidney, Bladder, Prostate or Reproductive Organs, Allergies, Anaemia or other Disorder of the Blood?	☐	☐
G.	Gout, Neuritis, Sciatica, Rheumatism, Arthritis or Disorder of the Muscles or Bones, Including Spine, Back or Joints?	☐	☐
H.	Deformity, Physical Impairment, Lameness, Back or Limb Disorder or Amputation?	☐	☐
I.	AIDS (Acquired Immune Deficiency Syndrome), ARC(AIDS related complex), any immunological Disorder or Positive HIV test?	☐	☐
J.	Cancer, Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, Unusual Skin Lesions, or Unexplained Infections, Tumour?	☐	☐
3.	Have you ever used or dealt in Barbiturates, Narcotics or other Drugs, Excitants or Hallucinogens, except as medication prescribed by a Physician?	☐	☐
4.	Are you now under observation or taking treatment?	☐	☐
5.	Other than the above, have you within the past 5 years:		
A.	been advised to have any Diagnostic Test, Hospitalization or Surgery which was not completed?	☐	☐
B.	had any Mental or Physical Disorder not listed above?	☐	☐
C.	had a Check-up, Consultation, Illness or Injury?	☐	☐
D.	been a patient in a Hospital, Clinic, Sanatorium or other Medical Facility?	☐	☐
E.	had an Electrocardiogram, Blood or other Special Tests?	☐	☐
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)***	☐	☐
8.	Have you done any flying as a pilot within the last two years?	☐	☐
9.	Have you had a request for Life or Health Insurance declined, postponed, rated or restricted in any way?	☐	☐
10.	Did your Father or Mother or any of your Brothers or Sisters, before attaining the age of 60, ever have:		
A.	Tuberculosis, Diabetes, High Blood Pressure, Heart Disease, Mental Disease or Polycystic Kidney Disease?	☐	☐
B.	Cancer? If yes, please state which family member and the type of Cancer	☐	☐
11.	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐	☐
12.	Have you within the last 2 years consulted a Physician? If so, please give in your opinion what the problem was. ***(If yes, kindly complete a Check-up Questionnaire)***	☐	☐
13.	To the best of your knowledge and belief, are you now in good health and free from any mental, physical deformity or defects?	☐	☐

14. **FEMALES ONLY**: ***(Please answer all questions)***

A. Are you now pregnant? ☐ YES ☐ NO

B. How far advanced? _____ weeks Expected Date of Delivery (EDD) _____

C. How many children do you have? _____ Pregnancies? _____ Any miscarriages? ☐ YES ☐ NO

D. Have you ever done or was asked to do a Pap Smear, Mammogram, Colposcopy, Breast or Pelvic Ultrasound? ☐ YES ☐ NO

E. Have you ever been told you had any Disorder of the Female Reproductive Organ, Pregnancy, the Pelvic area, Breast or Menstruation? ☐ YES ☐ NO

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 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 any records or knowledge of the above named employee/dependents or their health, to give SAGICOR LIFE INC. any such information.

Dated this_____ **Day of** _____ **20**_____

_____ _____ _____

Witness Signature **Employee Signature** **Spouse Signature** ***(if applicable)***

NOTE:

Is this form for a dependent child age 19 or older? ☐ YES ☐ NO
If yes, please include a letter from the school stating that the child is enrolled in full time study.

Does the dependent spouse have a different last name than the employee? ☐ YES ☐ NO
If yes, please include a copy of the marriage certificate or common law certificate.

Does the dependent child have a different last name than the employee? ☐ YES ☐ NO
If yes, please include a copy of the child's birth certificate.

Give complete details of all "Yes" answers in questions 1–5, 8-12 & 14 **PLEASE PRINT**
Give complete details if your answer is "No" to question 13

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