GROUP HEALTH STATEMENT – For Employee

All Changes and corrections **MUST** be initialled.

Company Name / Stamp	Group Policy No.	Certificate No.

Employee's Last Name	Employee's First Name	Employee's Address	Where Applicant is a married woman state Maiden Name:

Birth date DD/ MM / YYYY	Birthplace Country	Height Cm. Ft. Ins	Weight Kilos lbs	Weight Change in Past Year Gain Kilos/Lbs. | Loss 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, 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 if the Heart or Blood Vessels, Including: abnormal ECG, Elevated Cholesterol, Angina, Peripheral Vascular disease	☐	☐
E.	Jaundice, Intestinal Bleeding, Ulcer, Hernia, Appendicitis, Colitis, Diverticulitis, Haemorrhoids, 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) or any immunological disorder, 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, state type, quantity and frequency of use.)	☐	☐
7.	Have you done any flying as a pilot within the last two years?	☐	☐
8.	Have you had a request for Life or Health Insurance declined, postponed, rated or restricted in any way?	☐	☐
9.	Did your Father or Mother or any of your brothers or sisters, before attaining the age of 60, ever have Tuberculosis, Diabetes, High Blood Pressure, Heart Disease or Mental Disease?	☐	☐
10.	Are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a physician?	☐	☐
11.	Have you within the last 2 years consulted a Physician? If so please give in your opinion, what the problem was	☐	☐
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.	**FEMALES ONLY**:		
A.	Have you ever had any disorder of Menstruation, Pregnancy, the Pelvic area, Female Organs or Breasts?	☐	☐
B.	Are you now pregnant? (If yes, when is the birth expected?)	☐	☐
C.	Was last pregnancy normal?	☐	☐
D.	How many children have you had?		

PLEASE GIVE FULL DETAILS FOR ALL YES ANSWERS STATING DIAGNOSES, RESULTS, DATES AND NAMES OF ALL ATTENDING PHYSICIANS AND MEDICAL FACILITIES IN TABLE BELOW

Question No.	Date / Duration	Illness/ Disability Diagnosis	Treatment / Result	Names and Full Addresses of Doctors and Hospitals and supply 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. 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 me or my health, to give such information to **SAGICOR LIFE INC / SAGICOR CAPITAL LIFE INSURANCE COMPANY LIMITED** any such information.

…… …… ……

Date Employee Witness

GROUP HEALTH STATEMENT- For Dependants

Sagicor

Sagicor CAPITAL LIFE

All Changes and Corrections **MUST** be initialled

Company Name/Stamp		Group Policy No.	Certificate No.
Employee's Last Name	Employee's First Name		Maiden Name

Full Name of Eligible Dependants - Where Dependant Is A Married Woman, State Maiden Name Also.	Relationship To Employee	Birth Date Day/Month/Year	Height Ft. Ins. or Cm.	Weight Lbs. or Kilos.

1. Have any of the eligible dependants had any condition for which medical consultation or treatment is contemplated or has been advised? YES ☐ NO ☐

2. Have any of the eligible dependants ever consulted a physician, ever been treated for, or had any known indication of:

		YES	NO			YES	NO
(a)	Aids (Acquired Immunity Deficiency Syndrome) Arc (Aids Related Complex) or Any Immunological Disorder?	☐	☐	(g)	Nervous or Mental Disorder?	☐	☐
				(h)	Lung Disorder or Asthma?	☐	☐
(b)	Chest Pain Heart Disorder?	☐	☐	(i)	Small or Large Bowel Disorder	☐	☐
(c)	High Blood Pressure?	☐	☐	(j)	Stomach or Liver Disorder?	☐	☐
(d)	Cancer or Tumours?	☐	☐	(k)	Kidney or Urinary Disorder?	☐	☐
(e)	Diabetes?	☐	☐	(l)	Hernia?	☐	☐
(f)	Arthritis, Rheumatism or Rheumatic Fever?	☐	☐	(m)	Back or Limb Disorder?	☐	☐

3. Have any of the eligible dependants within the past 5 years experienced: Cancer, Enlargement of Lymph Nodes (Glands), Chronic Diarrhea, Unusual Skin Lesions, or Unexplained Infections? YES ☐ NO ☐

4. Have any of the eligible dependants had any Physical Impairments, Deformities or Illness not covered in questions 1, 2 and 3? ……..... YES ☐ NO ☐

5. Have any of the eligible dependants ever had

	YES	NO
(a) X-Ray Investigation	☐	☐
(b) An Electrocardiogram	☐	☐
(c) Blood or Other Special Tests	☐	☐

6. **ADULT FEMALES**: (a) Are you pregnant? ☐ YES ☐ NO If so, how many months? ……. (b) Was last pregnancy normal? ☐ YES ☐ NO
(c) How many children have you had? …… (d) Have you had any pelvic diseases? ☐ YES ☐ NO

7. Are all of the eligible dependants in first class health to the best of your knowledge and belief? ☐ YES ☐ NO

Give complete details of all yes answers in questions 1 – 6 **PLEASE PRINT**

PLEASE GIVE FULL DETAILS FOR ALL YES ANSWERS STATING DIAGNOSES, RESULTS, DATES AND NAMES OF ALL ATTENDING PHYSICIANS AND MEDICAL FACILITIES IN TABLE BELOW

Question No.	Name of Dependant	Date / Duration	Illness/ Disability Diagnosis	Treatment / Result	Names and Full Addresses of Doctors and Hospitals and supply 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. 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.

Dated this…….. day of …….…… 20……

…… …… ……. ……

Witness Employee/Guardian/Parent Signature of Spouse/Guardian/Parent