

GROUP HEALTH STATEMENT

THIS SECTION SHOULD BE COMPLETED BY THE EMPLOYEE
(PLEASE GIVE DETAILS TO "YES" ANSWERS FOR 1, 2, 3, 4, 7, 8 & 10 (e) ON REVERSE SIDE)
**** Corrections made to any questions in Employee/Dependent sections should be initialed and dated ****

Company Name			Group Policy No.			Certificate No.			
Employee's Last Name			Employee's First Name			Employee's Address			
Birth Date		Birthplace (Country)		Current Height		Current Weight		Weight change in past year	
Day	Month	Year		ft.	ins.	lbs		Gain	Loss
								lbs	lbs

1. Have you,
 - (a) ever applied for or received benefits, compensation or pension because of sickness or injury? Yes No
 - (b) been absent from work because of sickness or injury during the last six months? Yes No
 - (c) undergone treatment for alcoholism or drug habit? Yes No
 - (d) any condition for which medical consultation or treatment is contemplated or has been advised? Yes No

2. Have you ever consulted a physician, ever been treated for, or had any known indication of (underline illness if "Yes")
 - (a) AIDS (Acquired Immunity Deficiency Syndrome) ARC (AIDS related complex) or any Immunological disorder? Yes No
 - (b) Chest pain, Heart disorder, High Blood Pressure, Cancer or Tumors, Diabetes, Arthritis, Rheumatism or Rheumatic fever? Yes No
 - (c) Nervous or Mental disorder, Lung disorder or Asthma, Small or Large Bowel disorder, Stomach or Liver disorder? Yes No
 - (d) Kidney or Urinary disorder, Hernia, Back or Limb disorder, Allergies, Anemia or other disorders of the blood? Yes No

3. Have you within the past 5 years experienced:
 Cancer, Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, unusual Skin Lesions, or unexplained infections? Yes No

4. Have you any physical impairments, deformities, or illness not covered in questions 1, 2 and 3? Yes No

5. Have you done any flying as a Pilot within the last two years? Yes No

6. Have you had a request for Life or Health insurance declined, postponed, rated or restricted in any way? Yes No

7. Have you consulted any other physicians within the last two years? Yes No

8. Have you ever had:
 - (a) X-Ray investigation? Yes No
 - (b) An Electrocardiogram? Yes No
 - (c) Blood or other special tests? Yes No

9. Are you in first class health to the best of your knowledge and belief? Yes No

10. **ADULT FEMALES**
 - (a) Are you now pregnant? Yes No
 - (b) If so, how many months? _____
 - (c) How many children have you had? _____
 - (d) Was the last pregnancy normal? If "No", give details on reverse side Yes No
 - (e) Have you ever had any pelvic disease? Yes No

THIS SECTION SHOULD BE COMPLETED FOR ELIGIBLE DEPENDENTS
(PLEASE GIVE DETAILS TO "YES" ANSWERS FOR 1, 2, 3, 4, 5, 6 AND 8 (e) ON REVERSE SIDE)

1. Have the eligible dependent(s) any condition for which medical consultation or treatment is contemplated or has been advised? Yes No

2. Have the eligible dependent(s) ever consulted a physician, ever been treated for, or had any known indication of (underline illness if "Yes")
 - (a) AIDS (Acquired Immunity Deficiency Syndrome) ARC (AIDS related complex) or any Immunological disorder? Yes No
 - (b) Chest pain, Heart disorder, High Blood Pressure, Cancer or Tumors, Diabetes, Arthritis, Rheumatism or Rheumatic fever? Yes No
 - (c) Nervous or Mental disorder, Lung disorder or Asthma, Small or Large Bowel disorder, Stomach or Liver disorder? Yes No
 - (d) Kidney or Urinary disorder, Hernia, Back or Limb disorder, Allergies, Anemia or other disorders of the blood? Yes No
 - (e) undergone treatment for alcoholism or drug habit? Yes No

3. Have the eligible dependent(s) within the past 5 years experienced:
 Cancer, Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, unusual Skin Lesions, or unexplained infections? Yes No

4. Have the eligible dependent(s) any physical impairments, deformities, or illness not covered in questions 1, 2 and 3? Yes No

5. Have the eligible dependent(s) ever had:
 - (a) X-Ray investigation? Yes No
 - (b) An Electrocardiogram? Yes No
 - (c) Blood or other special tests? Yes No

6. Have your dependent(s) consulted any other physicians within the last two years? Yes No

7. Are all of the eligible dependents in first class health to the best of your knowledge and belief? Yes No

8. **ADULT FEMALES**
 - (a) Are you now pregnant? Yes No
 - (b) If so, how many months? _____
 - (c) How many children have you had? _____
 - (d) Was the last pregnancy normal? If "No", give details on reverse side Yes No
 - (e) Have you ever had any pelvic disease? Yes No

GROUP HEALTH STATEMENT - Employee Section

EMPLOYEE SECTION: Give full details of all "Yes" answers in questions 1, 2, 3, 4, 7, 8, 10 (e). PLEASE PRINT

Question No.	Date/Duration	Illness/Disability/Diagnosis	Treatment/Results	Names and full addresses of Doctors and Hospitals

EMPLOYEE SECTION: Give full details of all "Yes" answers in questions 5 and 6. PLEASE PRINT

Question No.	Details

GROUP HEALTH STATEMENT - Dependent Section

PLEASE LIST ALL ELIGIBLE DEPENDENTS. PLEASE PRINT

Full name of all eligible dependents	Relationship to Employee	Birth Date			Current Height			Current Weight		Address
		Day	Month	Year	ft.	ins	cm	lbs	kg	

FOR DEPENDENTS: Give full details of all "Yes" answers in questions 1, 2, 3, 4, 5, 6 and 8 (e). PLEASE PRINT

Question No.	Name of Dependent	Date/Duration	Illness/Disability/Diagnosis	Treatment/Results	Names and full addresses of Doctors and Hospitals

I HEREBY DECLARE that all the recorded answers included above and on the reverse are, to the best of my knowledge and belief, full complete and true as of this date.

Dated this..... day of20

.....
Witness

.....
Signature of Employee

.....
Signature of Dependent Spouse

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 records or knowledge of me or my health, or of my spouse and children or their health, to give SAGICOR LIFE INC. or SAGICOR CAPITAL LIFE INSURANCE COMPANY LIMITED any such information.

Dated this..... day of20

.....
Witness

.....
Signature of Employee

.....
Signature of Dependent Spouse