Sagicor

MEDICAL – CHILDREN

PART TWO OF CHILD'S APPLICATION

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. Please print names and addresses. The Proposed Owner must sign in the Examiner's presence. Examinations must be made in private. Please forward completed report in a sealed 'Confidential' envelope to the Underwriting Manager.

1. Full Name of Child Insured	2. a. Birthdate Day | Month | Year	b. Age

3. a. Name and address of Child's personal physician? (If none, so state)

_____

b. Date and reason last consulted? _____

c. What treatment was given or medication prescribed? _____

DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS): Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.

4. a. To the best of your knowledge has the Child been investigated or diagnosed for treatment or shown any indication of:-

(i) Any congenital or acquired abnormalities, deformities or hereditary disorders including haemoglobinopathies, allergies or AIDS. ☐ Yes ☐ No

(ii) Any heart trouble, asthma or other lung disease, diabetes or kidney disease? ☐ Yes ☐ No

(iii) Having cancer, tumour, anaemia, leukaemia or mental disorder? ☐ Yes ☐ No

(iv) Having received counselling or treatment regarding the use of alcohol, tobacco or substance abuse? ☐ Yes ☐ No

(v) Having in the last five years, consulted a physician, or been examined or treated at a hospital or other medical facility, for any illness, or injury or physical abuse? (State tests done.) ☐ Yes ☐ No

b. Has the Child received any blood transfusion or is under observation or treatment by a physician at present? ☐ Yes ☐ No

c. Are any medical investigations or operations recommended with respect to the Child in the future? ☐ Yes ☐ No

d. If the Child is less than two years of age, were there any problems during pregnancy or first year of life? ☐ Yes ☐ No

5. Has any of the Child's immediate family ever been treated for: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, AIDS or any inheritable disease? ☐ Yes ☐ No

Family History	Living		Dead	
	Age	State of Health	Age at death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

The answers above are given by me and are, to the best of my knowledge and belief, complete and true.

Dated at _____ this _____day of_____ 20____

_____ Signature of Proposed Owner

_____ Signature of Medical Examiner

_____ Signature of the Child (15 yrs of age & over)

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PART THREE OF
CHILD'S APPLICATION

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

Make a careful examination of heart and lungs with stethoscope against bare skin. With some histories, findings may have particular significance. Comments regarding relevant findings should be included under "Details" below.

Name of Agent

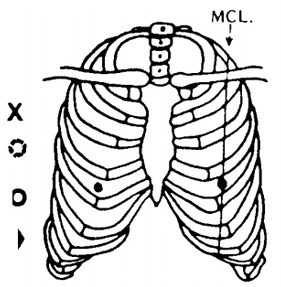
1. Birth Weight _____ Present Weight_____

   Present Height _____ Head Circumference_____

2. Heart: Is there any
   Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
   Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
   (describe below – if more than one, describe separately)

   Location

Constant	☐	☐	Indicate:
Inconstant	☐	☐	
Transmitted	☐	☐	Apex by X
Localized	☐	☐	Murmur area by ⟲
Systolic	☐	☐	Point of greatest intensity by D
Presystolic	☐	☐	
Diastolic	☐	☐	Transmission by ▸
Soft (Gr. 1-2)	☐	☐	
Mod (Gr. 3-4)	☐	☐	
Loud (Gr. 5-6)	☐	☐	



For comments and your impression?

   After exercise:

Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

3. Are there any hernias?..... ☐ Yes ☐ No

4. Are you in any way related to proposed Insured or Agents? Please circle which one. If "Yes" indicate relationship.
   ☐ Patient ☐ Casually ☐ Well Acquainted ☐ Other ☐ Yes ☐ No

5. Is the health of the Child likely to be affected unfavourably by conditions in the home or by the character of parents or guardians?..... ☐ Yes ☐ No

6. Do you find any evidence of past or present disease or impairment of:
   a. Respiratory System?..... ☐ Yes ☐ No
   b. Circulatory System?..... ☐ Yes ☐ No
   c. Digestive System?..... ☐ Yes ☐ No
   d. Genito-Urinary System?..... ☐ Yes ☐ No
   e. Nervous System?..... ☐ Yes ☐ No
   f. Bones, Joints, Glands, Eyes, Ears?..... ☐ Yes ☐ No

7. Are you satisfied that the Child is normally developed and free from disease, deformity or mental defect? ..... ☐ Yes ☐ No

Urinalysis : Specific Gravity	Albumin	Sugar

Are you sending a portion of the specimen to the Company's authorized laboratory for microscopic analysis? ☐ Yes ☐ No

Do you consider the Life to be average, under average, doubtful or bad?

If other than average, kindly given your reasons.

Details of "Yes" answers. (Identify item.)

I have carefully examined _____ this _____ day of _____, 20_____

at _____o'clock _____a.m./p.m.

Examination was made in private at ☐ my office ☐ residence of the Proposed Insured.

After completing above, please print in block letters (rubber stamp or typewriter will suffice) name and address:

Name:

Address:

_____
Signature of Examiner