Sagicor

Part 2 - Application for Life Insurance

Policy No.

NON-MEDICAL QUESTIONNAIRE

1. Full Name of Child Insured (Print)	2. a. Birth date	b. Age

3. a. Is the child below normal school grade for age? Yes ☐ ☐ No

b. Has the child lost more than 2 consecutive weeks from school in the past year due to sickness or injury? Yes ☐ ☐ No

c. Is the child's family subject to any chronic disorder? Yes ☐ ☐ No

d. Has the normal immunization programme been carried out? Yes ☐ ☐ No

Please provide any additional information that you feel is important or if the answer to any of question "3a" thru "d" is Yes.

_____

_____

4. Does the child have a personal physician? Yes ☐ ☐ No

Name and address of physician _____

Date physician last consulted _____

Disorder/Diagnosis _____

Results _____

Treatment given _____

Medication prescribed _____

5. Weight at birth _____lbs/Kg. Was the child's birth premature? Yes No If Yes, please amplify:

_____

6. Height _____ft/m ____in/cm Weight _____lbs/Kg.

Has weight changed in the past year?
If Yes, Gain _____lbs/Kg. Loss _____lbs/Kg.

☐ Average growth ☐ Increased exercise
☐ Diet ☐ Change in eating habits
☐ Illness ☐ Unknown
☐ Other _____

7. If the answer to questions 1 through 10 is "Yes", underline item and explain fully under #11".

Has the child ever suffered from or has a doctor been consulted about any signs or symptoms relating to:

1. Brain, nervous, spinal trouble or fits? Yes ☐ No☐
2. Nose, throat or lung trouble? Yes ☐ No☐
3. Heart or blood vessels, sickle cell disease or other blood disorder? Yes ☐ No☐
4. Digestive or intestinal trouble? Yes ☐ No☐
5. Kidney or bladder trouble? Yes ☐ No☐
6. Rheumatism, rheumatic fever or any disease of bones or joints? Yes ☐ No☐
7. Having cancer, tumor, leukemia or mental disorder? Yes ☐ No☐
8. Eye, ear or speech trouble? Yes ☐ No☐
9. Any operation, injury, gland trouble, allergy, diabetes or any other illness not mentioned above? Yes ☐ No☐
10. Has the child ever had an X-ray, blood or other special examination, or been hospitalized? Yes ☐ No☐
11. Amplify giving dates, treatment, results, names and addresses of Doctors, Hospitals etc

_____
_____
_____
_____
_____

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 this_____day of_____, Year_____

_____ Witness

_____ Signature of Parent/Guardian