Sagicor Global Health Insurance Application

Sagicor

Application Number :

Instructions: Please read all the agreement terms carefully and complete all sections. Enter the name of only those family members currently eligible.
NB: A Non-Medical is to be completed on all lives to be insured except when a routine Medical Examination is required. A Child's Non-Medical is to be used for dependants from 0 to 12 years.

SECTION 1 – PROPOSED INSURED (APPLICANT) INFORMATION

Name: First | Middle | Last | Maiden if married woman

If known by another name | Gender ☐ M ☐ F

Date of Birth (Day | Month | Year) | Age Nearest | Birthplace | Country of Residence

National Registration Number | Passport Number | Driver's Licence Number | Citizenship

Contact Information (*at time of application)*

Residence: No Street | City | Country | Duration

Mailing: No Street | City | Country

Telephone: Home | Work | Mobile | Email Address

Employment Information

Occupation/Profession Full Time | Duration

☐ Permanent ☐ Temporary ☐ Contract ☐ Self-employed

Industry/Exact duties (*If electrical, give voltage, offshore or high risk environment, dangerous machinery, Please indicate*)

Business Name | Telephone

Business Address: No Street | City | Country

Any intended change in occupation or location? If yes, state where and exact duties

Application Number:

SECTION 2 - SPOUSE INFORMATION			
Name: First	Middle	Last	Maiden if married woman

Residence: No Street	City	Country	Duration

Telephone: Home	Work	Mobile	Email Address

Occupation	Employer	Duration

SECTION 3 – INFORMATION ON ALL INDIVIDUALS TO BE COVERED

FULL NAME	D.O.B.	AGE	GENDER	NATIONALITY	PICTURE ID	RELATIONSHIP

SECTION 4 – COVERAGE INFORMATION

APPLICATION TYPE:

☐ New	☐ Upgrade	☐ Transfer	☐ Addition of Spouse or Dependant	☐ Other

COVERAGE TYPE:

☐ Individual	☐ Individual + 1	☐ Family

Application Number:	

SECTION 5 – OTHER HEALTH CARE COVERAGE

a) Are you or any dependant currently covered by a Sagicor Health Plan?	☐ Yes	☐ No
b) Were you or any dependants previously covered by a Sagicor Health Plan?	☐ Yes	☐ No
c) Do you or any dependants currently have any other Health policy?	☐ Yes	☐ No
d) Have you or any dependants ever applied for insurance which was declined, postponed, modified or rated?	☐ Yes	☐ No
e) Have you or any of your dependants received or applied for disability, Accident and Sickness or Critical Illness benefits?	☐ Yes	☐ No

If Yes, to any of the above questions, complete the following:

Insured	Policy #	Group/Company Name	Termination Date		
			Day	Month	Year

SECTION 6 - IF ANY OF THESE QUESTIONS ARE ANSWERED "YES", PLEASE STATE NAME AND GIVE COMPLETE DETAILS.

Have any of the lives to be insured:		
a) Ever or intend to participate in any hazardous sports or avocation? **(If yes, please complete Avocation questionnaire).**	☐ Yes	☐ No
b) Intend to fly other than as a passenger or any aircraft? **(If yes, please complete Avocation questionnaire).**	☐ Yes	☐ No

SECTION 7 – PURPOSE FOR HEALTH CARE COVERAGE

a) Is this a replacement of health or accident and sickness policy with Sagicor or another company that you presently have in effect?
☐ Yes ☐ No If yes, please state reason for replacement.

b) Is coverage a pre-requisite for university entry abroad? If yes, please provide name of university and copy of acceptance letter.

c) Other than short term vacation, are you or any dependants travelling abroad within the next 12 months? If yes, please complete Foreign Travel Questionnaire.

SECTION 8 - PREMIUM INFORMATION

FREQUENCY ☐ Annual

METHOD ☐ Direct Debit ☐ Banker's Order ☐ Salary Deduction

☐ Cheque ☐ Over the counter

Modal Premium $ _____ Amount paid with Application $ _____

Application Number:

SECTION 10 – DECLARATION

CONDITIONS OF COVERAGE

I declare, understand and agree that:

1. All applications are subject to acceptance and approval by Sagicor Life Inc (the Company). The Company will determine eligibility after it receives my application with payment and any necessary medical records or documentation. If the Company approves my application, the Company will notify me of the effective date of my coverage.

2. All representations and information supplied by me are true, complete and correct and are given to induce the issuance of the Contract. The Contract will be voided if any material statement or representation made herein is false or incomplete.

3. All terms and conditions of this coverage are specified in the Sagicor Life Inc. Global Health Contract, which shall be issued to me upon approval of the application. The application and all representations and statements made herein will be considered a part of the Contract**.**

4. The Company may need medical information to determine eligibility for coverage and benefits. I authorize any hospital skilled nursing facility, health maintenance organization, pharmacy, physician, dentist, pharmacists, professional review organization and any and all other providers of service to disclose and furnish to the Company any and all records relating to the Insured(s), including a complete diagnosis and all medical information for as long as the policy is in effect.

5. The Company is authorised to furnish to any Utilization Review Organisation, Insurer, Administrator or Law Enforcement Agency any and all medical records and information in relation to the insured(s) as deemed necessary by the Company of the administration of coverage.

6. Any injury that occurred on or before the date of this application or any sickness, the signs of which appeared on or before the date of this application, will not be covered under any policy issued by reason of this application.

7. Pre-existing conditions are not covered unless specified in a policy issued by reason of this application or any rider thereto.

Dated at ... .this.....day of ……year

Signature of Applicant: ..... Witness/Agent .....

Application Number:

AGENT'S REPORT

A. How long have you known the Proposed Insured? Years _____months _____

B. Are you related to the Proposed Insured? Yes ☐ No Relationship _____

C. Are you aware of any information concerning health, character, reputation, living environment, bankruptcy, questionable associates, financial difficulties, etc of the Proposed Insured(s)? ☐ Yes ☐ No
If yes, please give details

_____

D. Did you personally interview the Proposed Insured(s)? ☐ Yes ☐ No (If No, please advise)

_____

E. If juvenile, did you see the proposed insured(s) at time of completion of this application? ☐ Yes ☐ No
(If No state why)_____

F. Was any other person(s) present to answer questions? ☐ Yes ☐ No (If yes, please advise)

_____

G. Is the proposed insured blind or unable to read and/or write? If yes, Special Declaration form to be completed.

H. Is the proposed insured and /or applicant a politically exposed person? ☐ Yes ☐ No (If yes, please advise.

_____

I. Has the applicant purchased any Life, Health, Critical Illness or Personal Accident coverage with Sagicor within the last 12 months? If yes, state policy number(s) and type(s) of coverage.

Policy Number(s)	Type(s) of Coverage

J. Are you splitting this case? If Yes, Please complete the following: -

Agent(s)	Agent's Number	Agency	% split
1			
2			

K. 1. .Is a valid Photo ID attached? ☐ Yes ☐ No 2. Is verification of address document attached? ☐ Yes ☐ No

Additional remarks _____

_____

The above answers are true to the best of my knowledge and belief.

_____ _____
Agent's Signature Date

_____ _____
Branch Manager's Signature Date

AGENT SUPPORT – REVIEWER'S REPORT

1. Have all questions been answered? Yes ☐ No ☐
2. Has the full premium been paid? Yes ☐ No ☐
3. Have all required questionnaires and forms been completed and attached to this application? Yes ☐ No ☐
4. Have the medical requirements been met? Yes ☐ No ☐

PREMIUM RECEIPT

Application Number

APPLICANT, PLEASE KEEP THIS RECEIPT FOR YOUR RECORDS

Received from _____ the amount of $_____in _____currency as payment on account of the initial premium for a Sagicor Global Health Policy for which application has been made. This receipt does not constitute insurance coverage. There is no coverage unless Sagicor Life Inc approves the application and specifies an effective date of coverage, after which the Policy Owner will receive a policy contract and a health card for every adult person insured.

If your premium has not been reimbursed within 60 days after the date of this receipt and have you not received a policy, please notify us at the numbers listed below:

Agent's Printed Name: _____

Agent's Number: _____

Agent's Signature: _____ Date: _____

Agency: _____

Branch: _____

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Barbados

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