GROUP CREDITOR HEALTH STATEMENT
For Principal Borrower

Group Policy Number	Loan Number

Name of Credit Institution	Principal Borrower: Surname, First Name

Date of Birth (Day / Month / Year)	Non-Evidence Maximum (NEM)	Amount in Excess of NEM	Height (Ft. In.)	Weight (Lbs)	Weight Change in Past Year (Gain lbs / Loss lbs)

1. Have you,
   (a) undergone treatment for alcoholism or drug habit? ☐ Yes ☐ No
   (b) 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:
   (a) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex), Enlargement of Lymph Nodes (Glands), Chronic Diarrhoea, Unusual skin lesions or any Immunological disorder? ☐ Yes ☐ No
   (b) Chest pain, angina, murmur, stroke or heart disorder? ☐ Yes ☐ No
   (c) High Blood Pressure? ☐ Yes ☐ No
   (d) Cancer or tumors? ☐ Yes ☐ No
   (e) Diabetes? ☐ Yes ☐ No
   (f) Nervous or mental disorder? ☐ Yes ☐ No
   (g) Lung disorder or asthma? ☐ Yes ☐ No
   (h) Small or large bowel disorder? ☐ Yes ☐ No
   (i) Kidney or urinary disorder? ☐ Yes ☐ No
3. Have you within the past 5 years experienced: Anemia, Seizures, Arthritis, Hepatitis B or C, Colitis, Crohn's? ☐ Yes ☐ No
4. Have you any physical impairments, deformities, or illness not covered in questions 1, 2 and 3? ☐ Yes ☐ No
5. Give complete details of all YES answers in questions 1,2,3 and 4. PLEASE PRINT (Use reverse side if necessary)

Question No.	**Diagnosis/Date/Duration**	**Treatment/Results**	**Name and Full Addresses of Doctors and Hospitals**

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

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

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 any records or knowledge of me or my health, to give **Sagicor Life Inc.** any such information.

A photographic copy of this authorization shall be as valid as the original.

Dated this ____________________ day of ____________________ 20______

Address of Principal Borrower____

______________________ Witness

______________________ Signature of Principal Borrower