APPLICATION FOR REINSTATEMENT AND/OR POLICY CHANGE AND/OR ADDITION OF BENEFITS

INSTRUCTIONS – Use for a policy insuring one person only and lapsed more than 60 days

Policy Number	Policyowner	Life Insured (if other than Policyowner)

Full Address Telephone Number	All communications to be sent to
How long at above address	E-mail Address

1. The Policyowner applies for

   Reinstatement of a lapsed policy

   Addition of the Accidental Death and Dismemberment Benefit

   Addition of the Total Disability Waiver of Premium Benefit

   Policy change (give full details in space)

2. Other than this policy, has the life insured any insurance in this Company which

   (a) Has been issued or lapsed within the past year? Yes No

   (b) Will be lapsed or changed if this change is approved? Yes No

3. (a) Occupation and nature of duties	(b) Employer's name and address Telephone Number:
(c) Monthly income	

4. If any part of this question is answered "yes" give complete details

(a) Have you or do you intend to engage in hang gliding, parachuting, vehicle racing, skin or scuba diving or any other hazardous sport or hobby?	Yes No	
(b) Have you or do you intend to fly other than as a passenger? (If "yes", complete the attached aviation questionnaire)	Yes No	
(c) Do you smoke cigarettes, cigarillos, cigars or a pipe? (If "yes", indicate how many per day of each)	Yes No	
(d) Have you been a cigarette smoker in the past? (If "yes", indicate how many cigarettes per day and when and why you quit)	Yes No	
(e) Have you ever been told to quit cigarette smoking for medical reasons? (Give details and names of physicians)	Yes No	

5. List all existing life insurance contracts on the proposed life and applicant

Name of Company	Policy Number (If Available)	Face Amount	Accident Insurance	Date Purchased (Approximately)

6. Are you now a member of or do you expect to join the armed forces, active or reserve? Yes No

7. Height (in shoes): ft. ins.	8. Weight (in ordinary clothes): lbs.

9. Weight change during the last 12 months: None Gain lbs. Loss lbs.

10. Explain "Yes" answers, give dates, treatment, results, names and addresses of doctors, hospitals etc.

(a) Have you been refused life or health insurance or reinstatement or renewal of either or been offered a policy different in premium, plan, terms, or amount from that applied for?	Yes No	
(b) Has any member of your family suffered from tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or died by suicide?	Yes No	
(c) Have you		
(i) Undergone treatment for alcoholism or drug habit?	Yes No	
(ii) Joined any organization for control of alcoholism or drug habit?	Yes No	
(d) Have you had		
(i) An x-ray investigation?	Yes No	
(ii) An electrocardiogram?	Yes No	
(iii) Blood or other special tests?	Yes No	
(e) Have you had or been told you had any disease, illness, injury or disability?	Yes No	
(f) Have you consulted, been examined or treated by any doctor, practitioner, hospital or other institution not previously mentioned?	Yes No	
(g) Have you been advised to have any diagnostic test, hospitalisation or surgery which has not been completed?	Yes No	
(h) Have you ever had, been tested for, treated for, counselled for or told that you had:-		
(i) AIDS (Acquired Immune Deficiency Syndrome)?	Yes No	
(ii) ARC (AIDS related complex) or any immunological disorder?	Yes No	
(i) Have you within the past 5 years experienced enlargement of lymph nodes (glands), chronic diarrhoea, unusual skin lesions or unexplained infections?	Yes No	

11. **REMARKS AND SPECIAL INSTRUCTIONS**

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CORRECTIONS AND AMENDMENTS (Head Office Use Only)

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DECLARATION – The undersigned hereby declares that the statements and answers contained in this application and in the original application for the above policy, are full, complete and true as of the date hereof and expressly agrees that this application, and the statements and answers contained in any statement of health or questionnaire completed in connection with this application, (1) shall be the basis of the reinstatement and/or policy change and/or addition of benefits (2) shall not take effect until a certificate of reinstatement and/or acceptance has been issued by the Company and any overdue or additional premium paid, and shall then be effective only if all the statements and answers contained in this application are full, complete and true at the date of such acceptance, (3) acceptance by the Policyowner of any policy changed in accordance with this application shall constitute approval of the provisions of the policy and (4) the reinstated policy/or change/or benefits may be declared void by the Company if the Life Insured commits suicide, whether sane or insane, within two years of the date of acceptance referred to in item (2) above or if any of the statements and answers contained in this application are untrue.

If premiums are paid to an Agent of the Company prior to a certificate of reinstatement and/or acceptance being issued then such payments shall not create a binding contract between the undersigned and the Company; and in the event of this application not being accepted such payments shall be refunded to the undersigned.

It is suggested that the undersigned contact the Company if an official communication is not received within 20 days of the application being submitted to the Company.

Dated at ______________________ this ____________ day of ______________________ 20__________

Witness Signature	Witness Name (Block Letters)	Signature of Proposed Life Insured & ID Number
Witness Signature	Witness Name (Block Letters)	Signature of Owner(s) & ID Number (if other than Life insured)
Witness Signature	Witness Name (Block Letters)	Signature of Assignee (if any)

AUTHORIZATION

I hereby authorize any licensed Physician, Medical Practitioner, Clinic or any other medically related facility, Insurance Company, Medical Information Bureau or any other organisation, institution or person that has any records or knowledge of my health, to give Sagicor Life Inc. or its Reinsurers the right to obtain a Customer Report containing personal and financial information in connection with this application.

Dated at ______________________ this ____________ day of ______________________ 20__________

Witness Signature	Witness Name (Block Letters)	Signature of Proposed Life Insured
Witness Signature	Witness Name (Block Letters)	Signature of Proposed Insured (under Payors Waiver)
Witness Signature	Witness Name (Block Letters)	Signature of Owner(s) (if other than Life Insured)