Sagicor

BACK PAIN QUESTIONNAIRE

Name of Proposed Insured:	Policy No:

1. Date of onset of back pain? _____

2. How often does pain occur? _____

   _____

3. Location(s) of pain? _____

   Radiation to:_____

   _____

   _____

4. What will cause pain to start?_____

   _____

   _____

5. Name(s) of doctor(s) consulted and dates:

Name of Doctor (s)	Address of Doctor(s)	Date	Diagnosis

6. Any treatment? ☐ Yes ☐ No

   If "Yes" give details. _____

   _____

7. Are you limited in any way due to pain? ☐ Yes ☐ No

   If "Yes" give details. _____

   _____

   _____

8. Have you missed any time from work because of back pain? ☐ Yes ☐ No

If "Yes" give details. _____

_____

_____

I hereby agree that this supplement shall form a part of the application and of the policy issued thereunder, if any, and that it shall be binding on any person or persons who shall have or claim any interest under such policy. I have carefully read the above questions, statements, and answers and all such statements and answers are correctly recorded and are true as written above.

Dated this _____day of _____, 20_____

_____	_____	_____
Advisor/Witness	Signature of Proposed Insured	Applicant (*if other than Proposed Insured)*