MEDICAL EXAM - Part Two of Application

Every question must be asked by the Medical Examiner and the answers recorded in ink in the Examiner's own handwriting. Please print names and addresses. The Proposed Insured must sign in the Examiner's presence. Examinations must be made in private.

1. Full Name of Proposed Insured (Print)	Maiden Name (If Applicable)	2. a. Birthdate	b. Age

3. a. Name and address of your personal Physician?	Date of last visit	Reason and Results	Treatment/Medication Prescribed

	YES	NO
4. Have you ever been treated for, tested for, or ever had any known indication of:		
a. Disorder of eyes, ears, nose or throat?		
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis, transient ischemic attack, epilepsy, depression, multiple sclerosis, alzheimers, parkinsons, tremor, motor neuron disease, or stroke; mental or nervous disorder?		
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, turberculosis, sleep apnea or chronic respiratory disorder?		
d. Chest pain, palpitation, high blood pressure, rheumatic fever, angina, irregular pulse, cholesterol elevation, abnormal ECG, heart murmur, heart attack or other disorder of the heart or blood vessels or circulatory system?		
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, intestinal polyps, GERD, crohns, diarrhoea, or other disorder of the stomach, intestines, liver or gallbladder?		
f. Sugar, albumin, blood or pus in urine; sexually transmitted disease including Hepatitis B; stone, cysts or other disorder of the kidney, bladder, prostate or reproduction organs		
g. Diabetes; thyroid, pancreas, glandular disorder, or other endocrine disorders?		
h. Neuritis, sciatica, rheumatism, arthritis, gout, lupus, fibromyalgia, chronic fatigue or disorder of the muscles or bones, including the spine, back or joints?		
i. Deformity, lameness, loss of limb or amputation?		
j. AIDS (Aquired Immunodeficiency Syndrome), ARC (AIDS-Related Complex), HIV positive test, or any immunological disorder?		
k. Sickle cell disease or trait, other anemia, allergies or other blood disorders?		
l. Cancer, tumor, cyst, polyp, lump, discharge or any other malignancy?		
m. Any breast disorder, including swelling, cysts, unusual changes, lesions, discharge or abnormal mammogram or ultrasound?		
n. Do you have any tattoos or multiple body piercings?		
5. Within the last 12 months, have you used any product containing marijuana, tobacco, cigar, pipe, cotinine, including tobacco cessation products? If "Yes", what product did you consume, how much and how frequently?		
6. Does the Proposed Insured currently drink alcoholic beverages?		
7. Have you used:		
a. barbiturates, sedatives or tranquilizers habitually?		
b. L.S.D., marijuana, cocaine, stimulants or other amphetamine?		
c. Heroin, morphine or other narcotic drug?		
8. Have you within the past 10 years had a blood transfusion?		
9. In the past 10 years, have you been treated for alcoholism or any drug habit?		
10. Are you now under observation or taking treatment, including alternative therapy, herbal or special diet?		
11. Have you had any change in weight in the past year? If yes, how much?		
12. Other than above, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?		
b. Had a checkup, consultation, illness, injury, operation, or same day surgery?		
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?		
d. Had electrocardiogram, X-ray, colonoscopy, ultrasound, PSA or other diagnostic test?		
e. Been advised to have any diagnostic test, hospitalization, or surgery which was NOT completed?		
13. a. Have you suffered or are you suffering from any long-lasting chronic illness?		
b. Are you aware of any symptoms or complaints for which you have not yet consulted a doctor?		
14. Have any of your immediate family (including spouse, brothers or sisters) ever been treated for: tuberculosis, diabetes, cancer, growth or other malignancy, high blood pressure, stroke, heart or polycystic kidney disease, multiple sclerosis, alzheimer's disease or any mental or nervous disorder, AIDS, parkinson's, Lou Gehrig's disease, motor neuron disease sickle cell disease, Huntington's chorea, or any inherited disease?		

Daily: _____ _____ _____
Weekly: _____ _____ _____
(Stout/**Beer (bottle)** **Wine (glass)** **Liquor (# drinks)**)

15. Height
____Ft. ___Inches
_____ Cm.

16. Weight
_____ Lbs.
_____ Kg.

Details of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities).

If "Yes", state family member and age of onset.

Family History	Living		Dead	
	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Wife (Husband)				

17. Females Only:
a. Are you now pregnant? ☐ Yes ☐ No
b. How far advanced? _____months
c. How many children? _____ Pregnancies? ___
d. Any miscarriages? ☐ Yes ☐ No
e. Have you ever had or been told you had any disorder of the female reproductive organ, pelvis breast or menstruation? ☐ Yes ☐ No
f. Have you ever done or was asked to do a pap smear, mammogram, colposcopy, breast or pelvis ultrasound? ☐ Yes ☐ No (If yes, state date, reason and results)

_____

_____

I hereby declare that the foregoing answers are true and they shall be held to form part of the proposal for Insurance on my life with Sagicor Life Inc. Dated this_____day of_____, Year_____

_____ Witness

_____ Signature of Proposed Insured (Applicant if Proposed Insured is under 15)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institute or person, that has any records or knowledge of me or my health, to give to Sagicor Life Inc. any such information. A photographic copy of this authorization shall be as valid as the original. I also authorize Sagicor Life Inc. to release to my health care professional any medical information obtained for this insurance application including the results of any blood or urine tests or drug screening tests for purposes of revealing findings which might require further investigation or treatment or for purposes of explaining an underwriting decision.

_____ Date

_____ Signature of Proposed Insured (Applicant if Proposed Insured is under 15)

Sagicor

MEDICAL EXAM - PART THREE

MEDICAL EXAMINER'S REPORT TO BE FILLED OUT IN PRIVATE

Make a careful examination of heart and lungs with stethoscope against bare skin. With some histories, findings may have particular significance. Comments regarding relevant findings should be included under "Details" below.

Name of Agent

1. A. Height (without shoes) ___ft___in. _____Cm.

   B. Weight (clothed) _____lbs. _____ Kg.

3. Pulse Rate:	At rest	After Exercise	3 Minutes Later
Irregularities per min.			

2. Measurement – on bared skin
   Chest

   Forced inspiration_____ in. Forced expiration _____ in.
   Abdomen _____ in. Hip_____ in.

4. Blood Pressure. **Please record 3 readings**. With history of hypertension or if first reading is over 135 systolic or over 85 diastolic, take two additional readings at intervals.

Time			
Systolic			
Diastolic			

5. Heart: Is there any
   Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
   Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
   (describe below – if more than one, describe separately)

Location

Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐

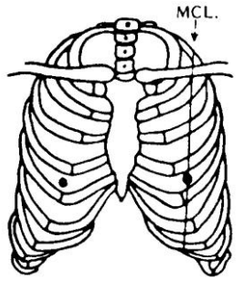
Indicate:

Apex by X

Murmur area by ↻

Point of greatest intensity by O

Transmission by ◗



For comments and your impression?

After exercise:

Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Details of "Yes" answers. (Identify item.)

6. Is there on examination any abnormality of the following:

a. Eyes, ears, nose, mouth, pharynx? ..... (if vision or hearing markedly impaired, indicate degree and correction).	☐ Yes	☐ No
b. Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐ Yes	☐ No
c. Nervous system (include reflexes, gait, paralysis)?	☐ Yes	☐ No
d. Respiratory system?	☐ Yes	☐ No
e. Abdomen (include scars)?	☐ Yes	☐ No
f. Genitourinary system?	☐ Yes	☐ No
g. Prostate? (Please examine from age 40 and over) ..... State whether the examination was refused.	☐ Yes	☐ No
h. Endocrine system (include thyroid and breast)?	☐ Yes	☐ No
i. Musculoskeletal system (include spine, joints, amputations, deformities)?	☐ Yes	☐ No

7. a. Are there any hernias? ..... ☐ Yes ☐ No
   b. Any Haemorrhoids? ..... ☐ Yes ☐ No

8. Are you in any way related to Proposed Insured or Agents? Which one and how related? ☐ Yes ☐ No

9. Are you aware of anything about the health, habits, environment or mode of life which might unfavourably affect the insurability of Proposed Insured? If "Yes", give details. *(A confidential report may be sent to the Medical Director)* ☐ Yes ☐ No

10. How long and how well have you known Proposed Insured?

Urinalysis : Specific Gravity	Albumin	Sugar	Blood
			If female, is Proposed Insured menstruating? ☐ Yes ☐ No

Are you sending a portion of the specimen to the Company's authorized laboratory for microscopic analysis?
☐ Yes ☐ No

Do you consider the Life to be average, under average, doubtful or bad?
If other than average, kindly give your reasons.

Send specimen to Laboratory If:-

(1) the applicant is over age 60, (2) you detect albumin, sugar or blood suspect recent disease of the urinary tract; (3) there is pronounced obesity, diabetes in the family or elevated blood pressure, or (4) advised by the agent.

I have carefully examined _____ this _____ day of _____, 20_____

at _____o'clock _____a.m./p.m.

Examination was made in private at ☐ my office ☐ residence of the Proposed Insured ☐ place of business of the Proposed Insured

After completing above, please print in block letters (rubber stamp or typewriter will suffice) name and address:
Name:

Address:

Telephone:

_____
Signature of Examiner