Sagicor

GROUP CREDITOR INSURANCE

PART A- TO BE COMPLETED BY THE EMPLOYEE USING BLOCK LETTERS OR PRINT
IMPORTANT: ALL QUESTIONS MUST BE ANSWERED USING 'YES, 'NO' OR 'N/A'

EMPLOYER:

Mortgagor:

Group Policy Number:

Date of Birth:

Present Occupation:

Height:

Weight:

THIS HEALTH STATEMENT IS BEING COMPLETED FOR: Employee only ☐ Employee & Dependents ☐ Dependents only ☐

Eligible Dependents (Spouse and children)	Relationship to Employee	Height	Weight	Date of Birth

Place Tick in Box	YES	NO
1. Are you employed on a full-time basis or working more than 30 hours every week?	☐	☐
2. Do you or any of your dependents have any physical impairment?	☐	☐
3. Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way?	☐	☐
4. During the last 5 years, have you or any of your dependents consulted, been treated or examined by a Doctor, had or been advised to have any tests, including blood tests?	☐	☐
5. During the last 45 years, have you or any of your dependents, undergone a surgical operation of being confined or treated in any hospital, sanitarium or other institution?	☐	☐
6. Have you or any of your dependents been treated for or told that they have Heart trouble, Blood Disease, High Blood Pressure, Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumor, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, AIDS, ARC or other dreaded disease not listed here on this application? {If "Yes', underline disease}	☐	☐
7. Are you or any of your dependents now receiving or contemplating or been advised to seek any medical attention of surgical treatment or taking any medication?	☐	☐
8. Are you or any of your dependents now pregnant?	☐	☐
9. Do you or any of your dependents have any disorder of the female organs or breasts		

If any of questions 2-9 are answered, 'Yes', give complete details below: {Continue on additional sheet if necessary}

Question Number	Full Name of Person Treated	Nature of Ailment	Date(s) of Visits	Degree of Recovery {F=Full; P=Partial; C=Continuing	Complete Name and Address of Attending Physician / Dentist

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I declare that all the statements are full, true and complete; I understand that they form the basis upon which any insurance will be made effective, I authorize my Physician, Hospital or other medically related facility to disclose to Sagicor Life Jamaica Limited information about my health, habits or medical history as well as that of any dependents listed. It is further understood that Sagicor Life Jamaica Limited reserves the right to request an examination by a Physician of their choice.

Date: ________________

Signature of Mortgagor: __________________________

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