Sagicor

APPL. REC'D DATE: _____
POLICY NO: _____
BRANCH: _____
ADVISOR: _____

APPLICATION FOR CHANGE/REINSTATEMENT

SECTION 1 LIFE INSURED

_____ Date of Birth _____/_____/_____

First Name | Middle Name | Last Name | Title | (dd/mm/yyyy)

_____

Current address: | City/Town | Parish/State | Country

_____

Occupation | Employer | Address of Employer

Telephone # Home _____ Mobile _____ E-mail address*_____

****The E-Service Application Form should accompany this application if the client has an E-mail address***

SECTION 2 POLICYOWNER

_____

First Name | Middle Name | Last Name | Title

_____

Current address: | City/Town | Parish/State | Country

_____

Occupation | Employer | Address of Employer

Telephone # Home _____ Mobile _____E-mail address_____

SECTION 3 APPLICATION FOR CHANGE

Application is hereby made to change Policy No. _____ as indicated below:

☐ Increase sum insured to $ _____ Amount of increase $ _____

☐ Decrease sum insured to $ _____

☐ Add ☐ Delete the following benefits: ☐ AD&D $ _____ ☐ WP

☐ PA Rider _____ units at Class _____

☐ Supplemental Term $ _____

☐ Other _____

☐ Reinstate Inflation Linking/Indexation % _____

☐ Other _____

Amount paid with this application $ _____

NB: Evidence of insurability on reverse side must be completed when increasing the sum insured or adding benefits

SECTION 4 ACKNOWLEDGEMENT FOR CHANGES TO EQUITY LINKED POLICY

I hereby acknowledge that I have received and read an information folder relating to the Equity Linked Policy now being changed

……
Signature of Applicant

SECTION 5 ACCEPTANCE AND CONSENT

Any change made in consideration of this application shall take effect, upon approval at Head Office, as of the date of completion of the application or upon the date of settlement of charges pursuant to the change, whichever is the later, provided that if settlement is not made within **sixty days of the date of this application,** the change shall be null and void. If evidence of good health and insurability is required by the company in connection with the change;

(a) The application shall be deemed to be completed on submission of such evidence as may be required (which evidence is hereby made part of this application) and the change shall be valid only if no alteration in the good health and insurability of the life insured has taken place between the date of submission of such evidence and the effective date of the change

(b) Any material misrepresentation made in this application or in any written statement submitted in connection therewith shall render the change null and void at the option of the Company, whereupon the terms of the policy immediately prior to the change shall prevail

(c) Death by Life Insured's own act, whether sane of insane, within two years from the effective date of this change shall render the change voidable at the option of the company.

Acceptance of the policy to change shall ratify any entries made by the Company in the space provided.

By my signature I consent to the change applied for by this application.

Signed at ……on the ……... day of ……20……

…….. ….. ……..
Signature of Life Insured | Witness

…….. ……
Signature of Owner, Beneficiary or Assignee | Witness

SECTION 6 APPLICATION FOR REINSTATEMENT

SAGICOR LIFE JAMAICA LIMITED is requested to reinstate Policy No. _____. It is agreed that:

(1) All statements and answers contained in Section 7 – Life Style Information and Section 8 – Evidence of Insurability and in any current medical report or questionnaire are the basis of and part of the consideration for the reinstatement.

(2) If within two years from the date of reinstatement, either the Life Insured dies by suicide whether sane or insane, or any of the said statements and answers are found to be incomplete or untrue in any material respect, the reinstatement shall take effect, if approved at the Head Office, as at the date of the application or the date of settlement of premium arrears, whichever is the later.

Signed at ……on the ……... day of ……20……

…….. ……..
Signature of Life Insured Witness

…….. ……..
Signature of Owner, if other than Life Insured Witness

Amount of money paid with this application $ _____

A If premiums were being paid by Pre-Authorized Payment, is bank information the same? Yes ☐ No ☐

B If premiums were being salary deducted, is authorization still in effect? Yes ☐ No ☐

C If answer to either question A or B is "No", indicate the new arrangements here ……

D Date salary deduction recommenced ……

E Besides policy shown above, how much insurance is in force, pending or being reinstated on your life?
In force $_____ Pending $_____ Being Reinstated $ _____

SECTION 7 LIFE STYLE INFORMATION	LIFE INSURED	OWNER
1. Have you smoked cigarettes, cigars, marijuana, or taken tobacco in any other form in the last 12 months? If yes, state quantity: per	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you used sedatives, tranquilizing, hallucinogenic or narcotic drugs except as prescribed by a physician? ***(If yes, complete Drug Usage Questionnaire)***	Yes ☐ No ☐	Yes ☐ No ☐
3. Do you currently drink beer, stout, wine, or strong liquor or ever received or been advised to seek treatment for or joined an organization because of excessive alcohol use? ***(If yes, complete Alcohol Usage Questionnaire)***	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you participated in or expect to participate in any hazardous avocation such as automobile and /or motor cycle racing, skin and scuba diving, hang gliding, skydiving/parachuting or any other hazardous sport activity? ***(If yes, complete Avocation Questionnaire)***	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you participated in or expect to participate in flying other than as a commercial passenger? ***(If yes, complete Aviation Questionnaire)***	Yes ☐ No ☐	Yes ☐ No ☐
6. Do you belong to any of the following AIDS high-risk groups? Homosexual or bi-sexual men, Intravenous drug users, haemophiliacs or other persons requiring repeated Blood Transfusion, prostitutes or persons who have sexual contact with prostitutes, sexual partners of the preceding groups or babies born to AIDS infected mothers. ***(If yes, please specify & provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
7. Have you been refused insurance or been offered insurance with an extra premium, rating or lien? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
8. Have you applied for or received compensation or a pension because of ill health, injury or disability? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐

SECTION 8 EVIDENCE OF INSURABILITY - *SINCE THE DATE OF THE ORIGINAL APPLICATION*		
1. Height and Weight in ordinary clothing for **Life Insured** and **Owner** (If applicable)	**Height:** **Weight:**	**Height:** **Weight:**
2. Have you had any illness, operation or injury? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you had any tests such as X-ray ECG, blood or any other special examination or investigation? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
4. Are you currently taking any medications, whether prescribed by a doctor or otherwise? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
5. Is there a history in parents or siblings of diabetes, epilepsy, mental, emotional or neurological disorder, TB, cancer, stroke, heart, kidney or circulatory disorder, high blood pressure, sickle cell disease or trait, hereditary disorder, Huntington's chorea or died before the age of 60?***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
6. Have you been tested for, treated for, counseled for or told you had AIDS, ARC, HIV, sexually transmitted infection, including Hepatitis B or any other immunological disorder? ***(If yes, provide details below)***	Yes ☐ No ☐	Yes ☐ No ☐
7. FEMALES ONLY: Are you now pregnant? If yes, how far advanced : ___ Months Name and address of Attending Physician/Clinic:	Yes ☐ No ☐	Yes ☐ No ☐
8. Are you now in good health and free from all symptoms and disease?	Yes ☐ No ☐	Yes ☐ No ☐

SECTION 9 ADDITIONAL INFORMATION - *SPECIFY SECTION AND RELATED QUESTION(S)*

(ATTACH AN A32 IF NECESSARY)

I authorize any physician or other person to disclose to the Company at any time or times hereafter all information in his/her possession as to my health and medical history upon the production of this authorization or a photocopy of this authorization to such physician or person

Signed at ……on the ……... day of ……20……

…….. ….. ……..
Signature of Life Insured Witness

…….. ……..
Signature of Owner, if other than Life Insured Witness