Sagicor

ACCELERATED BENEFIT CLAIM FORM

Name of Insured: _____

Address of Claimant: _____

Date of Birth: dd/mm/yyyy Taxpayer Registration Number: _____ Telephone No: (___) _____

Date of Diagnosis: dd/mm/yyyy Occupation at the time of Diagnosis: _____

In what capacity are you claiming: Insured ☐ Beneficiary ☐ Other ☐ _____

Have you submitted bills from Doctor/Hospital regarding the Insured's terminal illness? Yes ☐ No ☐

Politically Exposed Persons:
Are you or any of your immediate family members (parents, siblings, spouse, children or in-laws) a current or former senior official in the military, executive, legislative or administrative arms of government or judiciary of your country of residence or a foreign government or a senior officer of a foreign political party or a senior executive of an enterprise owned by your country of residence or a foreign government?
Yes ☐ No ☐ **If yes, kindly complete the Politically Exposed Persons (PEPs) Profile**.

Nature of Claim and Related Details

(i) Describe fully the extent and nature of Insured's illness:

_____

_____

_____

_____

(ii) Is Insured now totally and irreversibly disabled: _____

Details of all Physician(s) regarding your current condition:

NAMES	ADDRESSES	DATES OF ATTENDANCE

Policy(ies) for which you are claiming:

POLICY NUMBER	AMOUNT	POLICY NUMBER	AMOUNT

Sagicor

Sharing of Information:

(1) I/We understand and agree that the information I provide in this form and from time to time, including information regarding my accounts and business transactions with you (Customer Information) may be used for the following purposes: to confirm my identity, to augment and update currently held information, to provide me with accurate and up-to-date services, to manage and assess the company's risks, to satisfy information requests, and to meet legal and regulatory requirement.

(2) I/We further understand and agree that my Customer Information may be shared within the Company which includes its parent, subsidiaries, associated companies and affiliates, with third party service providers, credit bureaus and Regulators in and outside of the jurisdictions in which Sagicor does business for the purposes above and as may be required by law. I hereby warrant that the information provided herein is accurate and consent to the sharing and disclosure of my Customer Information for the purposes provided herein and as Sagicor may require from time to time.

Authorization:

I/We_____of _____

_____hereby certify that the above answers are full and true to the best of my knowledge and belief.

I/We hereby authorize and direct every person or institution of any nature whatsoever and without limiting the generality of the foregoing, any physician, hospital or government agency, to disclose fully to Sagicor Life Jamaica Limited or its duly authorized representative, all information in their possession or within their knowledge respecting _____, Insured or respecting the health and medical history, and to honor a photographic copy of this authorization, and this shall constitute full and sufficient authority for so doing.

Claim Fraud Warning:

I/We declare that the answers given above are complete and true and I/We understand that any false and or incomplete statement may result in the invalidity of this claim.

Dated at _____this_____day of _____20_____

_____ _____

Insured's Signature as on ID presented /Mark of Claimant | Signature (Witness) Staff/Justice of the Peace/Notary Public

_____ _____

Beneficiary's Signature as on ID presented /Mark of Claimant | Signature (Witness) Staff/Justice of the Peace/Notary Public

Note: The Company reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proofs of illness, age and title are the responsibility of the claimant.