Sagicor

CRITICAL ILLNESS CLAIM FORM

Name of Insured: _____ Policy Number(s) _____

Address of Claimant: _____

_____Telephone No: (___) _____ (___) _____

Date of Birth: _____ Taxpayer Registration Number: _____

Occupation at the time of Critical Illness: _____

Name and Address of Employer: _____

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**.

1. **Nature of Claim and Related Details**

   (i) Describe fully the extent and nature of your illness:

   _____

   _____

   _____

   (ii) Date of first medical consultation for your illness? _____

   _____

   (iii) Have you previously suffered from, or received treatment for, a similar or related illness? Yes ☐ No ☐

   If yes, give full details: _____

   _____

2. **Record of Medical Consultations:**

   (i) Give details of all Physician(s) who have been consulted regarding your illness:

NAME	ADDRESS	DATE OF CONSULTATIONS

   (ii) If you were treated at a Hospital or similar institution supply details:

NAME	DATE OF ADMISSION	DATE OF DISCHARGE

   (iii) Please provide the name and address of your medical attendant, if different from above:

(iv) Have any of your relatives suffered from a similar related illness? If 'yes', state: relationship, nature of illness and the date when the illness was first diagnosed. _____

_____

(v) Do you smoke cigarettes or any other substance? Yes ☐ No ☐ If yes,

(a) What is your daily consumption? _____ (b) For how long have you been smoking? _____

3. Are you insured for similar benefits with any other company? If 'yes', please provide details:

NAME OF COMPANY	AMOUNT AND TYPE OF BENEFIT	CLAIM SUBMITTED (yes or no)

4. State additional details relating to your illness (if necessary):

_____

_____

_____

_____

Sharing of Information:

(1) I 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 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_____of _____

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

I 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 declare that the answers given above are complete and true and I 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

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.