Sagicor

DISABILITY BENEFITS CLAIMANT'S STATEMENT

Name of Insured: _____ Policy Number(s) _____

Address of Claimant: _____

Taxpayer Registration Number: _____ Telephone No: (___) _____ (___) _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation at the time of Disability/Accident: _____ State your average weekly earnings: _____

Describe your duties: _____

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 present disability from beginning to present: _____

_____

_____

_____

(ii) Date of first medical consultation for your injury or beginning of illness resulting in present disability: _____

(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

3. List all other policies with any other Company which provides you with disability benefits or health insurance:

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

4. Total/Partial Disability:

a) State the date you have been unable to perform any work? _____

b) State causes or reasons for being unable to perform work? _____

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c) Have you ever been medically advised that you would be permanently disabled? _____

d) Has any of your family been affected with a similar condition? _____

e) Have you seen a Physician within the last 5 years for reasons other than your present condition? Yes ☐ No ☐

f) If yes, please state conditions, dates, names and addresses of Physician: _____

_____

_____

5. Medical Confinement:

a) Are you now a patient at a hospital or similar institution? Yes ☐ No ☐ If 'yes' give details: _____

_____

b) Are you now confined to house? Yes ☐ No ☐ If 'yes' state date: _____

6. Ability to resume work related activities:

i. State the duties you are currently doing work and when you began: _____

ii. If not, when do you return to work? _____

7. **Have you ever received a pension from any government, or benefits from any Life, Accident or Health Company, or Benefit Society or Workmen's Compensation?** Yes ☐ No ☐ If 'yes' state when and from which Company. _____

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.