

GROUP HEALTH STATEMENT For Child Dependants aged 14 or younger.

A new form must be completed by the Employee for each Dependant.

Please answer <u>all</u> questions. Please give complete details of all "Yes" answers in questions 1-11. Please give complete details if your answer is "No" to question 12. Please state diagnoses, results, dates, and names of all attending physicians and medical facilities in table on the next page. Any changes or corrections MUST be initialled.

Company Name / Stamp				Group Policy N	10.	Certificate No.
Employee's Last Name	Employee	e's First Name	Maiden Na	ame (if applical	ble) Employee's	Address
Child Dependant's Last Name		Child Dependant's First Na	me		Relationship to E	Employee
Child's Date of Birth DD / MM / YYYY	Age	Birthplace			Country of Birth	

		N/A	Yes	No
1.	Has the child had any condition for which medical consultation, investigation, operation or treatment is contemplated or has been advised?			
2.	Is the child below normal school grade for age?	🗆		
3.	Has the child lost more than 2 consecutive weeks from school in the past year due to sickness or injury	🗆		
4.	Has the normal immunization programme been carried out?			
5.	If the child is less than 2 years of age, were there any problems during pregnancy or first year of life?	□		
6.	Does the child have a personal physician or was seen by any doctor, clinic, or institution?			

If "Yes", please answer the following questions:		
Name of Personal Physician / Doctor last visited	Physician's Address	Physician's Office Phone
Date last consulted	Reason for consultation Regular Check Up Other	zation
If "Other", please provide the following details	Disorder/Diagnosis	
	Results	
	Treatment Given	
	Medication Prescribed	

7. Was the child's birth premature?.....

Weight at birth: _____ Lbs _____ Oz / _____ Kgs

If "Yes", please provide additional details below:

8. Child's details:

(a)	Height: Ft In / m cm	
(b)	Weight: Lbs Oz / Kgs	
(c)	Has the weight changed in the past year?	
	lf "Yes", Gain: Lbs / Kgs Loss: Lbs / Kgs	
	Reason:	

9.	To t	o the best of your knowledge has the child been investigated or diagnosed for treatment or shown any signs or symptoms relating to:				
	(a)	Brain, nervous system, down syndrome, mental disorder, fits, or epilepsy?				
	(b)	Nose, throat, allergies, asthma or other lung disease?				
	(c)	Heart or blood vessels, chest pain, sickle cell disease, anaemia, or other blood disorder? \Box				
	(d)	Digestive, stomach, intestinal, jaundice or liver disorder? \Box				
	(e)	Kidney or bladder disorder?				
	(f)	Arthritis, rheumatism, lupus, rheumatic fever or any disease of bones or joints? \Box				
	(g)	Having cancer, tumour, leukaemia, enlargement of lymph nodes (glands) chronic diarrhoea, unusual skin lesions, or unexplained infections?				
	(h)	Eye, ear, or speech trouble?				
	(i)	Any congenital or acquired abnormalities, hereditary disorders including haemoglobinopathies, or AIDS?				
	(j)	Diabetes, sugar, albumin, blood or pus in urine, thyroid, pancreas, or other endocrine disorder?				



				Yes	No
			ars, had any operation, consulted a physician, or been examined or treated at a hospital or ness, or injury or physical abuse?	□	
	(I) Has the child received any blood transfusion or is under observation or treatment by a physician at present?				
	(m) Hernia, disorder or deformity of limbs, muscles or bones including spine, back or joints?			□	
10.	Has	the child ever had	(a) X-Ray, Ultrasound or Scan	🗆	
			(b) An Electrocardiogram	🗆	
			(c) Blood or Other Special Tests		
			(d) Any Hospitalization	□	
11.	Has	the child had any physical impa	irments, or illnesses not covered in questions 1-10 above?	□	
12.	Is th	e child in first class health to the	best of your knowledge and belief? If No, please provide full details below.	□	

Please give FULL DETAILS for all "Yes" answers for question 1-11 or any "No" answer to question 12, stating diagnoses, results, dates, and names of all attending physicians and medical facilities in table below.

Question #	Name of Child	Date / Duration	IIIness/ Disability/ Diagnosis	Treatment / Result	Names and Full Addresses of Doctors and Hospitals and supply Medical Reports where applicable

DECLARATION: I have read all the recorded answers included above and declare that, to the best of my knowledge and belief, they are full, complete and true, as of this date. Sagicor Life Inc / Sagicor Life (Eastern Caribbean) Inc must be notified if there is a symptom or diagnosis of any condition between this application date, the acceptance of the risk and effective date coverage. I am aware that if any untrue statement has been made or information necessary to be made known to the Insurer has been withheld, the benefits applied for shall be absolutely null and void.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution, person or medical information bureau that has or may hereafter any records or knowledge of the above-named employee / dependant or their health, to give Sagicor Life Inc / Sagicor Life (Eastern Caribbean) Inc any such information.

Employee Signature

Date

Witness Name (Block Letters)

Witness Signature