Sagicor GENERAL

Sagicor General Insurance Inc.
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KEY PROTECTOR TRAVEL INSURANCE PROPOSAL FORM

PLEASE COMPLETE IN CAPITALS THROUGHOUT

PROPOSER'S NAME MRS. _____ OCCUPATION _____

PERMANENT ADDRESS _____ TELEPHONE NO (H) _____

_____ (W) _____

1. DURATION AND COMMENCEMENT DATE OF TRAVEL: _____ DAYS/MONTHS FROM _____ OF _____ 2 _____

2. WHAT IS THE PURPOSE OF YOUR VISIT ABROAD? _____ 3. DESTINATION _____

4. HAVE YOU BEEN INSURED BEFORE FOR ANY OF THE RISKS PROPOSED? NO

i) IF YES, WHO WAS YOUR INSURER? _____

ii) HAVE YOU EVER HAD ANY INSURANCE REFUSED OR DECLINED? NO

i) HAVE YOU EVER BEEN CONVICTED OF, OR BEEN CHARGED WITH ANY OFFENCE INVOLVING DISHONESTY SUCH AS FRAUD OR HANDLING STOLEN PROPERTY? NO

ii) HAVE YOU SUSTAINED LOSS OR DAMAGE BY ANY OF THE RISKS YOU NOW WISH TO INSURE? NO

iii) IF YES, DETAILS OF ANY CLAIMS:-

DATE OF LOSS	DETAILS OF CLAIM & INSURER	TOTAL AMOUNT PAID OUT

	D.O.B	PREMIUM
1. THE PROPOSER (AS NAMED ABOVE)		
FULL NAMES OF ALL PERSONS TO BE INSURED:		
2.		
3.		

PACKAGE SELECTED: CLASSIC ☐ ECONOMY ☐ TOTAL PREMIUM : $
STAMP DUTY : $

PACKAGE OPTIONS	LIMIT PER INSURED CLASSIC	ECONOMY
SECTION A PERSONAL ACCIDENT (PERSONS AGED 16-70 YRS)	$100,000.	$50,000.
SECTION B MEDICAL EXPENSES (PERSONS UP TO AGE 70)	$50,000.	$25,000.
SECTION C PERSONAL LUGGAGE & PERSONAL MONEY	$6,000.& $750.	$3,000. & $500.
SECTION D CANCELLATION OR CURTAILMENT CHARGES	$5,000.	$2,000.
SECTION E PERSONAL LIABILITY	$50,000.	$25,000.
SECTION F DEPARTURE DELAY	$500.	$500.

AREA AND PREMIUM COST GUIDE

AREA 1: THE ISLANDS OF THE CARIBBEAN INCLUDING THE BAHAMAS, BERMUDA & TURKS & CAICOS ISLANDS. (EXCLUDES CUBA, DOMINICAN REPUBLIC, HAITI & U.S. TERRITORIES)
AREA 2: WORLDWIDE

AREA	PERIOD NOT EXCEEDING	PREMIUM PER PERSON CLASSIC	ECONOMY
1	3 DAYS	150	75
2		210	114
1	10 DAYS	180	90
2		245	130
1	20 DAYS	225	112
2		306	158
1	31 DAYS	262	135
2		358	175
1	45 DAYS	315	165
2		428	210
1	61 DAYS	375	202
2		490	262
1	EACH ADDT. WEEK UP TO	38	22
2	6 MONTHS	52	35

CHILDREN UNDER 12 CHARGED 75% OF ABOVE RATES.
CHILDREN UNDER 2 TRAVELLING WITH PARENT (S) / GUARDIAN (S) INSURED HEREIN, ARE COVERED UNDER THE ECONOMY PLAN.
(NO CHARGE IF LISTED ON SCHEDULE).

P.T.O.⇒

HEALTH QUESTIONNAIRE

All questions must be answered. Failure to give complete information or to date and sign this questionnaire will necessitate our returning it to you delaying acceptance.

Proposer's I.D. Number _____ **Telephone Number** _____

NAME OF APPLICANT (PLEASE PRINT NAME IN FULL)	SEX	BIRTH DATE	HEIGHT	WEIGHT

Address _____

1. Name and Address of your personal physician? (If none, so state) _____

a) Date and reason last consulted? _____

b) What treatment was given or medication prescribed? _____

c) Results? _____

2. Have you ever been tested, received medical advice counselling or treatment in connection with HIV/AIDS or an AIDS-related condition, or any form of sexually transmitted diseases or Hepatitis B? NO

a) If answer is "Yes", what were the results? _____

3. Are you in good health and free from defect and all symptoms of illness and disease? NO

a) If answer is "No", please give details. _____

PLEASE READ CAREFULLY – THIS SECTION MUST BE DATED AND SIGNED

IT IS HEREBY UNDERSTOOD AND AGREED THAT COVER UNDER THIS POLICY IS IN RESPECT OF UNEXPECTED ILLNESS OR ACCIDENT ONLY DURING THE PERIOD OF INSURANCE.

IT IS FURTHER UNDERSTOOD AND AGREED THAT upon presentation of the original or a photo-copy of this signed questionnaire I authorize any medical professional, hospital, clinic other medical or medically related facility, governmental agency or other person or firm to provide the Company with any information including copies of records concerning advice, care or treatment provided to me including without limitation information related to mental illness or use of drugs or alcohol.

I do hereby declare that the statements and answers made herein are complete and correct. Should any statements or answers given be untrue (if such statements and answers are fraudulent or material to the acceptance of this application), then the contract may be cancelled by the Company, and their obligation shall consist only of the return of any subscription charges actually paid, less the amount of any benefits paid under the contract.

Dated _____ Signature of Applicant _____

HEALTH WARRANTY

PLEASE READ CAREFULLY BEFORE SIGNING PROPOSAL. THE ADMISSION OF CLAIMS UNDER SECTIONS A, B & D OF THE POLICY IS SUBJECT TO THE EXPRESS WARRANTY THAT ANY ***(I)*** INSURED OR ***(II)*** PERSON WITH WHOM THE INSURED HAS ARRANGED TO TRAVEL OR STAY, WAS NOT TO THE BEST OF THE KNOWLEDGE AND BELIEF OF THE INSURED PHYSICALLY OR MENTALLY CHALLENGED, SUFFERING FROM INFIRMITY, DISEASE OR ILLNESS OR RECEIVING OR AWAITING MEDICAL OR SURGICAL TREATMENT AT THE TIME OF EFFECTING THE INSURANCE. THIS POLICY DOES NOT COVER TRAVEL UNDERTAKEN FOR THE PURPOSE OF OBTAINING MEDICAL TREATMENT.

DISCLOSURE

ALL IMPORTANT FACTS WHICH MAY AFFECT THE ACCEPTANCE OR ASSESSMENT OF THE COVERAGE REQUESTED BY THIS PROPOSAL MUST BE DISCLOSED. IF YOU ARE IN DOUBT ABOUT WHAT IS IMPORTANT, ASK US OR YOUR PROFESSIONAL ADVISER. FAILURE TO DISCLOSE THESE FACTS MAY INVALIDATE THE POLICY.

DECLARATION

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE INFORMATION ON THIS FORM IS TRUE IN EVERY RESPECT. I ALSO DECLARE THAT IF ANYTHING ON THIS FORM WAS WRITTEN BY ANOTHER PERSON, HE OR SHE ACTED AS MY AGENT FOR THIS PURPOSE. I AGREE THAT THIS PROPOSAL AND DECLARATION WILL BE THE BASIS OF THE CONTRACT BETWEEN ME AND THE COMPANY.

THE COMPANY RESERVES THE RIGHT TO REFUSE ANY PROPOSAL.

_____ _____

DATE **SIGNATURE OF PROPOSER**