Sagicor

APPLICATION FOR REINSTATEMENT AND/OR POLICY CHANGE AND/OR ADDITION OF BENEFITS

INSTRUCTIONS – Use for a policy insuring one person only and lapsed more than 60 days

Policy Number	Policyowner	Life Insured (if other than Policyowner)
Maiden Name (if Applicable)	Birth date (Day/ Month/Year)	Age
Full Address Telephone Number	All communications to be sent to	
How long at above address	E-mail Address	

Name and address of your personal Physician?	Date of last Visit	Reason and Results	Treatment/Medication Prescribed

Details of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS: Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities).

1. Have you ever been treated for, tested for, or ever had any known indication of:	YES	NO		YES	NO
a. Disorder of eyes, ears, nose or throat?			h. Neuritis, sciatica, rheumatism, arthritis, gout, lupus, fibromyalgia, chronic fatigue or disorder of the muscles or bones, including the spine, back or joints?		
b. dizziness, fainting, convulsions, headache, speech defect, paralysis, transient ischemic attack, epilepsy, depression, multiple sclerosis, alzheimers, parkinsons, tremor, motor neuron disease, or stroke; mental or nervous disorder?			i. Deformity, lameness, loss of limb or amputation?		
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, turberculosis, sleep apnea or chronic respiratory disorder?			j. AIDS (Acquired Immunodeficiency Syndrome), ARC (AIDS - related complex), HIV positive test, or any immunological disorder?		
d. Chest pain, palpitation, high blood pressure, rheumatic fever, angina, irregular pulse, cholesterol elevation, abnormal ECG, heart murmur, heart attack or other disorder of the heart or blood vessels or circulatory system?			k. Sickle cell disease or trait, other anemia, allergies or other blood disorders?		
e. Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, intestinal polyps, GERD, crohns, diarrhoea, or other disorder of the stomach, intestines, liver or gallbladder?			l. Cancer, tumor, cyst, polyp, lump, discharge or any other malignancy?		
f. Sugar, albumin, blood or pus in urine; sexually transmitted disease including Hepatitis B; stone, cysts or other disorder of the kidney, bladder, prostate or reproduction organs			m. Any breast disorder, including swelling, cysts, unusual changes, lesions, discharge or abnormal mammogram or ultrasound? …………………………………		
g. Diabetes; thyroid, pancreas, glandular disorder, or other endocrine disorders?			n. Do you have any tattoos or multiple body piercings?		

	YES	NO
2. Within the last 12 months, have you used any product containing marijuana, tobacco, cigar, pipe, cotinine, including tobacco cessation products? If "Yes", what product did you consume, how much and how frequently?		
3. Does the Proposed Insured currently drink alcoholic beverages? Stout/**Beer (bottle)** **Wine (glass)** **Liquor (# drinks)** Daily: ________ ________ ________ Weekly: ________ ________ ________		
4. Have you used:		
a. Barbiturates, sedatives or tranquilizers habitually?		
b. L.S.D., marijuana, cocaine, stimulants or other amphetamine?...		
c. Heroin, morphine or other narcotic drug?..		
5. Have you within the past 10 years had a blood transfusion?		
6. In the past 10 years, have you been treated for alcoholism or any drug habit?		
7. Are you now under observation or taking treatment, including alternative therapy, herbal or special diet?		
8. Have you had any change in weight in the past year? If yes, how much?		
9. Other than above, have you within the past 5 years:		
a. Had any mental or physical disorder not listed above?		
b. Had a checkup, consultation, illness, injury, operation or same day surgery?		
c. Been a patient in a hospital, clinic, sanatorium or other medical facility?...........................		
d. Had electrocardiogram, X-ray, colonoscopy, ultrasound, PSA or other diagnostic test? ………………………………………………….		
e. Been advised to have any diagnostic test, hospitalization, or surgery which was NOT completed?		
10. a. Have you suffered or are you suffering from any long-lasting chronic illness?....................		
b. Are you aware of any symptoms or complaints for which you have not yet consulted a doctor?		
11. Have any of your immediate family (including spouse, brothers or sisters) ever been treated for: tuberculosis, diabetes, cancer, growth or other malignancy, high blood pressure, stroke, heart or polycystic kidney disease, multiple sclerosis, alzheimer's disease or any mental or nervous disorder, AIDS, parkinson's, Lou Gehrig's disease, motor neuron disease sickle cell disease, Huntington's chorea, or any inherited disease?		

If "Yes", state family member and age of onset.

Family History	**Living**		**Dead**	
	Age	**State of Health**	**Age at Death**	**Cause of Death**
Father				
Mother				
Brothers				
Sisters				
Wife (Husband)				

12. Height ________ Ft. ________ Inches ________ Cm.	13. Weight ________ Lbs. ________ Kg.

14. **Females Only:**
a. Are you now pregnant? ☐ Yes ☐ No
b. How far advanced? _____________months
c. How many children? ________ Pregnancies? ______
d. Any miscarriages? ☐ Yes ☐ No
e. Have you ever had or been told you had any disorder of the female reproductive organ, pelvis breast or menstruation? ☐ Yes ☐ No
f. Have you ever done or was asked to do a pap smear, mammogram, colposcopy, breast or pelvis ultrasound? ☐ Yes ☐ No
(If yes, state date, reason and results)______________________________

15. The Policyowner applies for
☐ Reinstatement of a lapsed policy
☐ Addition of the Accidental Death and Dismemberment Benefit
☐ Addition of the Total Disability Waiver of Premium Benefit
☐ Policy change (give full details in space)

16. Other than this policy, has the life insured any insurance in this Company which:

a. Has been issued or lapsed within the past year? ☐ Yes ☐ No
b. Will be lapsed or changed if this change is approved? ☐ Yes ☐ No

17. a. Occupation and nature of duties

b. Employer's name and address

c. Monthly income

Telephone Number:

18. If any part of this question is answered "yes" give complete details

(a) Have you or do you intend to engage in hang gliding, parachuting, vehicle racing, skin or scuba diving or any other hazardous sport or hobby? ☐ Yes ☐ No
(b) Have you or do you intend to fly other than as a passenger? (If "yes", complete the attached aviation questionnaire) ☐ Yes ☐ No
(c) Do you smoke cigarettes, cigarillos, cigars or a pipe? (If "yes", indicate how many per day of each) ☐ Yes ☐ No
(d) Have you been a cigarette smoker in the past? (If "yes", indicate how many cigarettes per day and when and why you quit) ☐ Yes ☐ No
(e) Have you ever been told to quit cigarette smoking for medical reasons? (Give details and names of physicians) ☐ Yes ☐ No

19. List all existing life insurance contracts on the proposed life and applicant

Name of Company	Policy Number (If Available)	Face Amount	Accident Insurance	Date Purchased (Approximately)

20. Are you now a member of or do you expect to join the armed forces, active or reserve? ☐ Yes ☐ No

21. **REMARKS AND SPECIAL INSTRUCTIONS**

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CORRECTIONS AND AMENDMENTS (Head Office Use Only)

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DECLARATION – The undersigned hereby declares that the statements and answers contained in this application and in the original application for the above policy, are full, complete and true as of the date hereof and expressly agrees that this application, and the statements and answers contained in any statement of health or questionnaire completed in connection with this application, (1) shall be the basis of the reinstatement and/or policy change and/or addition of benefits (2) shall not take effect until a certificate of reinstatement and/or acceptance has been issued by the Company and any overdue or additional premium paid, and shall then be effective only if all the statements and answers contained in this application are full, complete and true at the date of such acceptance, (3) acceptance by the Policyowner of any policy changed in accordance with this application shall constitute approval of the provisions of the policy and (4) the reinstated policy/or change/or benefits may be declared void by the Company if the Life Insured commits suicide, whether sane or insane, within two years of the date of acceptance referred to in item (2) above or if any of the statements and answers contained in this application are untrue.

If premiums are paid to an Agent of the Company prior to a certificate of reinstatement and/or acceptance being issued then such payments shall not create a binding contract between the undersigned and the Company; and in the event of this application not being accepted such payments shall be refunded to the undersigned.

It is suggested that the undersigned contact the Company if an official communication is not received within 20 days of the application being submitted to the Company.

Dated at ________________________________ this ____________ day of ______________________ 20___________

Witness Signature	Witness Name (Block Letters)	Signature of Proposed Life Insured & ID Number
Witness Signature	Witness Name (Block Letters)	Signature of Owner(s) & ID Number (if other than Life insured)
Witness Signature	Witness Name (Block Letters)	Signature of Assignee (if any)

AUTHORIZATION

I hereby authorize any licensed Physician, Medical Practitioner, Clinic or any other medically related facility, Insurance Company, Medical Information Bureau or any other organisation, institution or person that has any records or knowledge of my health, to give Sagicor Life Inc. or its Reinsurers the right to obtain a Customer Report containing personal and financial information in connection with this application.

Dated at ________________________________ this ____________ day of ______________________ 20___________

Witness Signature	Witness Name (Block Letters)	Signature of Proposed Life Insured
Witness Signature	Witness Name (Block Letters)	Signature of Proposed Insured (under Payors Waiver)
Witness Signature	Witness Name (Block Letters)	Signature of Owner(s) (if other than Life Insured)