28-48 Barbados Avenue, Kingston 5 Jamaica W.I.

CRITICAL ILLNESS CLAIM FORM

PERSONAL STATEMENT	**POLICY N0.**
This form must be completed by the person in respect of whom the benefit is being claimed	
The issue of this form is in no way an admission of liability	
1. Personal Particulars	
Surname:	First Names:
Address:	
Occupation:	Date of Birth:

2. Nature of Claim and Related Details
(i) **Describe fully the extent and nature of your illness:**
(ii) **On what date did you first consult a medical practitioner in connection with your illness?**
(iii) **Have you previously suffered from, or received treatment for, a similar or related illness YES [ ]NO [ ]** **If 'yes', give full details.**

3. Record of Medical Consultations		
(i) **Give below the details of any doctors or specialists who have been consulted in connection with your illness:**		
Name:	Address:	Date of Consultations:
(ii) **If you were treated at a hospital or similar institution supply details:**		
Name of Hospital or Institution:	Date of Admission:	Date of Discharge:
(iii) **Please provide the name and address of your usual medical attendant, if different from above:**		

4. General

(i) **Have any of your blood relatives suffered from a similar related illness? If ‘yes’, state: relationship, nature of illness and the date when the illness was first diagnosed.**

(ii) **Are you insured for similar benefits with any other company? If ‘yes’, state the name of the insurer, the amount of benefit and whether or not you have submitted a claim in connection with such benefits.**

(iii) **Do you smoke cigarettes? YES [ ] NO [ ]. If yes,**

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

Declaration

I hereby declare that all answers given by me in this statement are, to the best of my knowledge and belief true and complete. I consent to Sagicor Life Jamaica Limited. Seeking medical information from any doctor who, at any time, has attended me concerning anything which affects my physical and mental health or seeking information from any Insurance Office to which a proposal has been made for insurance on my life and I authorize the giving of such information.

Dated this ……………………………day …………………………………………….20….......

…………………………………………. (Witness)

…………………………………………….. (Signature of Claimant)

1……………………………………………..

…………………………………….. (Telephone Contact)

2…………………………………………….. (Address)

Space for Additional Details (if necessary)