STATEMENT OF CRITICAL ILLNESS FORM

	Yes	N
1. Have you ever been treated or diagnosed with any form of cancer?	( )	( )
2. Have you ever been diagnosed with a condition that potentially could be cancerous, such as elevated PSA, abnormal Pap Smear or abnormal biopsy?	( )	( )
3. Have you ever been treated or diagnosed as being HIV positive?	( )	( )
4. Have you ever been treated or diagnosed with a heart condition?	( )	( )
5. Have you ever been treated or diagnosed with a stroke?	( )	( )
6. Have you ever had an application for Life or Health Insurance declined, postponed, rated or in any way modified?	( )	( )
7. Are you now receiving **or** contemplating any medical attention, surgical treatment or taking any medication?	( )	( )

If you answered yes to any of the above questions, please provide details.

Q#	***Details As To Nature Of Ailment***	***Duration Of Illness***	***Degree Of Recovery (Total, Partial Or Continuing)***	***Name, Address And Telephone # Of Attending Physician***

I declare that all statements are full, true and complete and understand that they form the basis upon which insurance will be made effective. I authorize my Physician, hospital or other medically related facility to disclose to Sagicor Life Jamaica Limited any additional information about my health habits or my medical history.

Name_____ Signature_____ Company:_____ Date:__/____/20___