Sagicor

28-48 Barbados Avenue, Kingston 5 Jamaica W.I.
Telephone (876)929-8920-9 Fax (876) 929-4730

CONFIDENTIAL MEDICAL CERTIFICATE

Name:	
Date of Birth:	**Policy Number**:

The above named, insured against the happening of certain events associated with his/her health, has submitted a Claim in connection with_____.
To enable us to assess the claim, we should be obliged if you would complete this report and return it directly to our Individual Life Claims Department.

Part 1. GENERAL

1) Are you the Insured's usual medical attendant? YES [ ] NO [ ]
If yes, over what period do your records extend?_____

2) When were you first consulted for this disease and, at that time, how long had the symptoms been present?_____.

3) (a) Has the Insured previously suffered from the condition specified above, or any related illness?

YES [ ] NO [ ]

(b) Has the Insured ever been tested for HIV antibodies?
(If yes, please give dates and results)

YES [ ] NO [ ]

_____.

4) On which date did the Insured first become aware of the disease? State specifically._____.

5) Is there anything in the Insured's Family History that would have increased the risk of the present condition? _____.

6) Please give details of the Insured's smoking habits_____.

7) If there is any additional information which in your opinion will assist in the processing of this Claim, please supply details below:

_____
_____
_____

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Part 2. DETAILS OF THE SPECIFIC ILLNESS

CANCER, HEART ATTACK, PARAPLEGIA, STROKE, COMA 3rd° Burns
Please underline the specific illness and complete the relevant section:-

CANCER

8) (a) What is the site or organ involved? State the precise histology of the Tumour. (Please attach laboratory report(s)).

_____

(b) What stage has the disease reached? Please describe using either Staging or other Classification._____

(c) Please give details of treatment (surgical or otherwise) Pre and Post diagnosis.

_____

(d) If the diagnosis is Leukaemia, or Plasma Cell dyscrasias, please provide details of actual type. _____

HEART ATTACK

9) (a) Date and Time and Place of the attack. _____

(b) Please give details of and the results of ALL laboratory tests, ECG's, Xrays or other diagnostic tests done. _____

_____

(c) Details of treatment (surgical or otherwise), Pre and Post diagnosis.

_____

PARAPLEGIA

10) (a) Date Insured became paralysed _____

(b) State the proximate cause(s) of the paralysis _____

(c) Any predisposing conditions? _____

(d) Results of any diagnostic tests, Xrays done _____

(e) Is the Insured Permanently or Temporarily disabled? _____

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STROKE – (excluding Transient Ischaemic attacks and reversible Ishaemic Neurological defects)

11) (a) Time and Date of the cerebro-vascular accident _____

(b) Give details of permanent neurological sequelae, giving evidence of permanent damage_____
_____

(c) Details or treatment (surgical or otherwise), Pre and Post Diagnosis _____
_____

COMA

12) (a) Date insured became comatosed _____ How long has the coma lasted _____

(b) State the proximate cause(s) of the coma _____

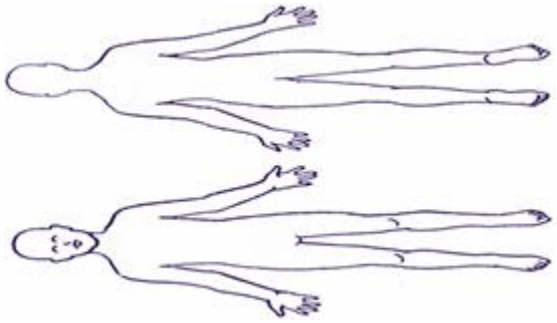
(c) Any predisposing conditions? _____

(d) Results of any diagnostic tests, Xrays done _____

(e) Will the Insured be permanently or Temporarily disabled? _____

THIRD DEGREE BURNS

13) (a) Please indicate on the diagram the extent of the burns (Back and or Front)



(b) What percentage of the body do you estimate to be injured? _____

Kindly provide copies of relevant hospital/clinic reports where they are available

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BLINDNESS

14) (a) Date insured became blind

(b) Is the blindness in one or both eyes?

(c) Is the insured permanently or temporarily disabled

(d) Has the insured ever been diagnosed with Glaucoma?

(d) If the answer is (Yes), was the insured on treatment for Glaucoma?

DEAFNESS

15) (a) Date insured became deaf

(b) Is the deafness in one or both ears

(c) Is the insured permanently or temporarily disabled

LOSS OF SPEECH

16) (a) Date the insured suffered loss of speech

(b) What is the cause of the loss of speech? (eg, Physical injury or disease?)

(c) Is the insured permanently or temporarily disabled?

…….. ……

Signature of Physician/Surgeon

……

Please print name and Address of Practice

…….

Date