

## **HEALTH STATEMENT - GROUP INSURANCE**

GROUP POLICY NO.

PART A - TO BE COMPLETED BY EMPLOYEE IF REQUESTING INSURANCE ON SELF	Y EMPLO	YEE	REQUESTING	INSURANC	EON	SELF			
1. Name			2. Ac	Address		Ţ			
9.	Date	Mth.	Day	Year		City	Country		
3. Sex	4. of Birth				5. of Birth	, ,			
6. Height Ft. In	7. Weight	ht	lbs.		8. 00	Occupation			
9. Have you at any time been treated for or been told you had any trouble with any of the following (answer each item "yes" or "no" [] in space provided)	eated fo	r or be	en told you had provided)	any trouble	e with	any of the	following?		2
<b>X</b>	Yes No			7	Yes No			Yes	No
Heart		Lungs				Urinary	Urinary system		
Tumors		Diabetes	es			Nervou	Nervous disorders		
High blood pressure		Kidneys	S			Stomac	Stomach or intestines		
Cancer		3ack o	Back or Joints			Hernia			
Answer each of the following questions 10 - 15 "yes" or "no" [	estions 1	0 - 15		] in the space provided.	e provi	ded.		Yes	N <sub>S</sub>
10. Have you been a patient in a hospital or similar institution during the past three years?	hospital	or sin	ilar institution d	luring the p	ast thi	ee years?			
11. Have you been examined by, or consulted a doctor during the past three years?	or consu	llted a	doctor during t	he past thre	ee year	,s?			
12. Have you been advised to ent	er a hosp	oital o	other institutior	n for diagno	osis, res	t or treatr	advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	25	
13. Have you been advised to have a surgical operation or procedure but did not do so?	ve a surg	ical o	peration or proc	edure but o	did not	do so?			
14. Have you any known physical impairments, deformities, or ill health not covered from questions	Impairr	nents,	deformities, or il	Il health no	t cover	ed from c	luestions 9 -13?		
15. If female, are you pregnant?									
16. Have you ever had an application for o postponed, rated or any way modified?	ition for modified	or reir	had an application for or reinstatement of Life Accident or Health Insurance declined, ed or any way modified?	e Accident	or Hea	Ith Insura	nce declined,		
17. Do you intend to seek medical advice, treatment, or have any medical tests performed?	al advice	, treat	nent, or have an	y medical t	ests pe	erformed?			
If you have answered "yes" to any of the above questions 9 - 17, give below details including name and address physician(s), reason(s) for visits and dates attended, reason(s) and results of treatment.	of the al	oove c	uestions 9 - 17, gled, reason(s) an	give below id results of	details	including nent.		attending	g <sub>C</sub>
Indicate question number when answering.	answerin	ō,		E					
Aids (Acquired Immune Deficiency Syndrome) Questions - describe in details any affirmative answers.  Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease? Have you been told you had AIDS or AIDS RELATED COMPLEX? Have you had or been told you had a positive blood test for antibodies to the AIDS VIRUS? (Human Immune Deficiency Virus).	y Syndro vice, or to Have yo	ome) ( eatmour bee t for a	uestions - descrint, in connectior n told you had A ntibodies to the	ribe in detain with AIDS	ils any or an / RELAT	affirmativ AIDS relate ED COMP an Immur	e answers. ed condition or a LEX? Have you had or ne Deficiency Virus).	Yes	S S
2. Do you have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhoea, Enlarged Lymph Nodes.	ing whic	n are u	nexplained: Fatic	gue, Weight	Loss, [	)iarrhoea,	Enlarged Lymph Node	.5.	
If you have answered "yes" to any of the above questions 1 -2, give below details including name and address of attending physician(s), reason(s) for visits and dates attended, reason(s) and results of treatment.	of the ak	oove o	uestions 1 -2, giv ed, reason(s) and	ve below de d results of	etails in	ncluding r	name and address of a	attendir	бг
Indicate question number when answering	answerin	ģ	a.						
I hereby declare that all statements and all answers to the above questions are complete and true and they are the basis on which insurance is requested under the Group Policy.	nd all ans he Group	wers to Policy	the above questi	ons are com	plete a	nd true and	they are the basis on		
by authorize any doctor or o n <b>idad and Tobago, Ltd.</b> any talization.	r practitic ormation	ner ar it requ	d any hospital or s ests about me witl	sanitorium to h reference t	o give t o any t	he <b>Pan-An</b> reatments,	nerican Life Insurance C examinations, advice or	Compan	>
PART B - TO BE COMPLETED BY EMPLOYER	Witness	1		Signat	ture of	Signature of Employee			
From a health standpoint do you know of any reason why the employee should not be covered index your Ground January		Yes No	o if "yes" give details and dates.	etails and da	tes.				
Has the employee been absent from	<u> </u>								
work because of sickness or injury during the past six months?	gui								

		imployee_	_ Signature of Employee		- Witness		Date	D
surance Company of s, advice or	erican Life In examination:	e Pan-Amoreatments,	erence to any t	I hereby authorize any doctor or other practitioner and any hospital or sanitorium to give <b>Pan-American Life Insurance Company of Trinidad and Tobago, Ltd.</b> any information it requests about me with reference to any treatments, examinations, advice or hospitalization.	r other practitions information it req	ze any doctor o <b>bago, Ltd.</b> any	I hereby authoriz <b>Trinidad and To</b> l hospitalization.	z ฮ =
the basis on which	and they are t	and true	ns are complete	I hereby declare that all statements and all answers to the above questions are complete and true and they are the basis on which insurance is requested under the Group Policy.	ents and all answe	that all stateme sested under th	nereby declare surance is requ	5' =
= 1 1 20 20 20	=			reason(s) for visits and dates attended, reason(s) and results of treatment. Indicate question number when answering	tended, reason(s) answering	ts and dates att	reason(s) for visits and dates attended, reason landicate question number when answering	=   =
If you have answered "yes" to any of the above questions 1 -2, give below details including name and address of attending physician(s),	nd address of	ng name ar	details includir	estions 1 -2, give below	ny of the above qu	ered "yes" to ar	you have answ	=
lodes.	ged Lymph N	hoea, Enlar	ight Loss, Diarrl	Do you have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhoea, Enlarged Lymph Nodes.	owing which are u	any of the folk		5
exually Yes No	ndition or a sı ı had or been rus)	related co ? Have you ficiency Vii	NIDS or an AIDS NTED COMPLEX: nan Immune De	Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease? Have you been told you had AIDS or AIDS RELATED COMPLEX? Have you had or been told you had a positive blood test for antibodies to the AIDS VIRUS? (Human Immune Deficiency Virus)	advice, or treatme you been told you sst for antibodies t	ceived medical disease? Have ositive blood te		
- 1	8	tive answe	etail any affirma	Aids (Acquired Immune Deficiency Syndrome) Questions - describe in detail any affirmative answer.	ncy Syndrome) Q	mmune Deficie	ids (Acquired In	Þ
NAME AND ADDRESS OF PHYSICIANS AND HOSPITALS		COMPLETE RECOVERY MO. YR	DURATION OF DISABILITY	DETAILS DF ATTACKS SO STATE)	CONDITION, DETAILS AND NUMBER OF ATTACKS (IF OPERATED, SO STATE)	QUESTION NO.	NAME OF PERSON	
			17	What are the full particulars of all "yes" answers to 3 (a) through 3 (g)?	rs of all "yes" answ	e full particula		4
		ij	performed?	intend to seek medical advice, treatment, or have any medical tests performed?	vice, treatment, or	ek medical adv		ب
	6)7	hrough 3 (	do so?	been advised to have a surgical operation or procedure but did not do so? has any known physical impairments, deformities, or ill health not covered by 3 (a) through 3 (a)?	rgical operation o pairments, deforr	ed to have a sui own physical im	•	.⊸ io
	ot do so?	: but did no	est or treatment	been advised to eliter a libspital of other institution for diagnosis, rest or treatment but did not do so?	ospital of other ins	ed to eliter a lic		,
			s?	been examined by or consulted a doctor during the past three years?	sulted a doctor du	ined by or cons		ъ io
Yes No			ee years?	been a patient in a hospital or similar institution during the past three years?	al or similar institu	ent in a hospita		Þ
Hernia?	Back joints?	Bac	Cancer?	Stomach or intestines?	1	ssure? Kidneys?	High blood pressure?	-
Nervous disorders?	Diabetes?	Dia	Tumors?	Urinary system?	s? Urina	Lungs?	Heart?	_
tem "yes" or "no"):	answer each i	ollowing (a	vith any of the f	at any time been treated for or been told such person had trouble with any of the following (answer each item "yes" or "no"):	or or been told su	been treated f	a. at any time	T
					ame above:	Have any of the persons name above:	<ol><li>Have any of</li></ol>	Liv
	N.		,		nts?	Address of your dependents?	2. Address of	N
						27		
ì								
11								
For Company use only		Height Weight	Birth Date	Relationship to You		Full Name		$\top$
าal form.)	plete addition	eded com	(If more space needed complete additional form.)		pendents?	Who are your eligible dependents?	1. Who are yo	
	ENTS	DEPEND	JRANCE FOR	FAN C-10 BE COMPLETED BY EMPLOYEE REQUESTING INSURANCE FOR DEPENDENTS	ED DI EMPLOT	SE COMPLETE		1

REMARKS:

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HS/EBD:

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