PAN AMERICAN LIFE
INSURANCE OF TRINIDAD AND TOBAGO
A member of the Pan-American Life Insurance Group

HEALTH STATEMENT - GROUP INSURANCE

GROUP POLICY NO.

PART A - TO BE COMPLETED BY EMPLOYEE IF REQUESTING INSURANCE ON SELF

First Middle Initial Last

1. Name	2. Address	
Male Female	Mth. Day Year	City Country
3. Sex	4. Date of Birth	5. Place of Birth
6. Height Ft. In	7. Weight lbs.	8. 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)

	Yes	No		Yes	No		Yes	No
Heart			Lungs			Urinary system		
Tumors			Diabetes			Nervous disorders		
High blood pressure			Kidneys			Stomach or intestines		
Cancer			Back or Joints			Hernia		

Answer each of the following questions 10 - 15 "yes" or "no" [ ] in the space provided.	Yes	No
10. Have you been a patient in a hospital or similar institution during the past three years?		
11. Have you been examined by, or consulted a doctor during the past three years?		
12. Have you been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?		
13. Have you been advised to have a surgical operation or procedure but did not do so?		
14. Have you any known physical impairments, deformities, or ill health not covered from questions 9 -13?		
15. If female, are you pregnant?		
16. Have you ever had an application for or reinstatement of Life Accident or Health Insurance declined, postponed, rated or any way modified?		
17. Do you intend to seek medical advice, treatment, or have any medical tests performed?		

If you have answered "yes" to any of the above questions 9 - 17, give below details including name and address attending physician(s), reason(s) for visits and dates attended, reason(s) and results of treatment.

Indicate question number when answering.

Aids (Acquired Immune Deficiency Syndrome) Questions - describe in details any affirmative answers.	Yes	No
1. 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).		
2. Do you have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhoea, Enlarged Lymph Nodes.		

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.

Indicate question number when answering.

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.

I hereby authorize any doctor or other practitioner and any hospital or sanitorium to give the **Pan-American Life Insurance Company of Trinidad and Tobago, Ltd.** any information it requests about me with reference to any treatments, examinations, advice or hospitalization.

Date_____ Witness_____ Signature of Employee _____

PART B - TO BE COMPLETED BY EMPLOYER

	Yes	No	if "yes" give details and dates.
From a health standpoint do you know of any reason why the employee should not be covered under your Group Plan?			
Has the employee been absent from work because of sickness or injury during the past six months?			

PART C - TO BE COMPLETED BY EMPLOYEE REQUESTING INSURANCE FOR DEPENDENTS

1. Who are your eligible dependents? (If more space needed complete additional form.)

Full Name	Relationship to You	Birth Date	Height	Weight	For Company use only

2. Address of your dependents?

3. Have any of the persons name above:

a. at any time been treated for or been told such person had trouble with any of the following (answer each item "yes" or "no"):

Heart?	Lungs?	Urinary system?	Tumors?	Diabetes?	Nervous disorders?
High blood pressure?	Kidneys?	Stomach or intestines?	Cancer?	Back joints?	Hernia?

	Yes	No
b. been a patient in a hospital or similar institution during the past three years?	☐	☐
c. been examined by or consulted a doctor during the past three years?	☐	☐
d. been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	☐	☐
e. been advised to have a surgical operation or procedure but did not do so?	☐	☐
f. has any known physical impairments, deformities, or ill health not covered by 3 (a) through 3 (e)?	☐	☐
g. intend to seek medical advice, treatment, or have any medical tests performed?	☐	☐

4. What are the full particulars of all "yes" answers to 3 (a) through 3 (g)?

NAME OF PERSON	QUESTION NO.	CONDITION, DETAILS AND NUMBER OF ATTACKS (IF OPERATED, SO STATE)	DURATION OF DISABILITY	COMPLETE RECOVERY MO. YR	NAME AND ADDRESS OF PHYSICIANS AND HOSPITALS

Aids (Acquired Immune Deficiency Syndrome) Questions - describe in detail any affirmative answer.

	Yes	No
1. 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)	☐	☐
2. Do you have any of the following which are unexplained: Fatigue, Weight Loss, Diarrhoea, Enlarged Lymph Nodes.	☐	☐

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.

Indicate question number when answering

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.

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Date_____ Witness_____ Signature of Employee_____

REMARKS: