Beacon

Registered Office
13 Stanmore Avenue, PO Box 837
Port of Spain, Trinidad & Tobago
(t) +1 868 623 2266
(f) +1 868 623 9900
info@beacon.co.tt
beacon.co.tt

PART 1 OF APPLICATION FOR GROUP INSURANCE

Application No.....

ANY STATEMENT MADE ON THIS APPLICATION THAT IS FRAUDULENT, WHETHER INNOCENTLY MADE OR MADE WITH INTENT, WILL RESULT IN COVERAGE EITHER BEING NOT EFFECTED OR IF COVERAGE IS ALREADY EFFECTED, SUCH COVERAGE WILL BE TERMINATED FORTHWITH.

Proposed Insured..... **Birth Date**.....
First Name Middle Initial Last Name Day Month Year

PLEASE ANSWER TO THE BEST OF YOUR KNOWLEDGE OR BELIEF

1. a. Name and address of your personal physician?..... *(If none, so state)*
   b. Date and reason last consulted? (If within the past 10 years).....
   c. What treatment was given or medication prescribed?.....

	Yes	No
2. Have you ever been treated for or ever has any known indication of: (TICK APPLICABLE ITEMS)		
a. Disease or disorder of eyes, ears, nose, or throat?.....	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disease or disorder?.....	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysems, tuberculosis or chronic respiratory or lung disease?.....	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels?.....	☐	☐
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulities, haemorrhoids, recurrent indigestion, or other disease of the stomach, intestines, liver or gallbladder?.....	☐	☐
f. Sugar, albumin, blood or pus in urine; veneral disease: stone or other disease of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disease?.....	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disease or dis-order of the muscles or bones, including the spine, back or joints?.....	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disease of skin, lymph glands, cyst, tumor, or cancer?.....	☐	☐
k. Allergies; anemia or other disease of the blood?.....	☐	☐
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?....	☐	☐
3. Are you now under observation or taking treatment or medication for any disease or disorder?.....	☐	☐
4. Have you had any change in weight in the past year?.....	☐	☐
5. Have you within th past 5 years:		
a. Had any mental or physical disease or disorder not listed above?.	☐	☐
b. Had a checkup, consultation, illness, injury, surgery?.....	☐	☐
c. Been a patient in a hospital, clinic, sanatorium, or other medical facility?.....	☐	☐
d. Had electrocardiogram, X-ray, other diagnostic test?.....	☐	☐
e. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?.....	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?.....	☐	☐
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?.....	☐	☐
8. Has an application for life or health insurance on yourself ever been declined, rated or modified in any way? When?..... What Company?.....	☐	☐
9. Have you ever been tested, received medical advice, counselling or treatment in connection with AIDS or an AIDS-related condition, or any form of sexually transmitted disease, including hepatitis B?	☐	☐
10. Have you within the past five years, experienced or suffered from continuous fatigue, unexplained weight loss, persistent fever, chronic diarrhoea, persistent night sweats, enlarged lymph nodes, cough or unexplained skin lesions?.....	☐	☐
11. Have you ever taken drugs for other than medicinal purposes?	☐	☐
12. Have you ever suffered from or had any investigations for any blood disorder?.....	☐	☐
13. Have your natural parents, brothers or sisters, whether living or dead, suffered from any of the following medical conditions? Heart disease, stroke, hypertension, diabetes, kidney disease, cancer (please indicate type of cancer), multiple sclerosis, Alzheimer's, motor neuron disease, Parkinson's, and other inherited disease? If, yes, please provide the following details:	☐	☐

If the answer to any question is "Yes", identify question number and include diagnosis, dates, duration, degree of re-covery or results and names and addresses of all attending physicians and medical facilities.

	Age if Living?	Condition	Age first Diagnosed	Age at Death?
Father				
Mother				
Brothers and Sisters No. Living..... No. Dead.....				

14. a. Height.....ft.....in. of.....cm.
    b. Weight.....lbs. or.....kilos.

FEMALES ONLY:

15. To the best of your knowledge and belief:	Yes	No
a. Have you ever had any disorder of menstruation pregnancy or of the female organs or breasts?.....	☐	☐
b. Are you now pregnant?.....	☐	☐
(If yes, how many months).....	☐	☐

I represent that I am the person named as the Proposed Insured Person and that the foregoing statements and answers which are made in Part One of this application, each of which I have made and read are complete, true and correctly recorded and are a continuation of, and form a part of the application for Group Life AD&D and Health Insurance Coverage to The Beacon Insurance Company Limited.

I hereby authorise any physician, clinic, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to The Beacon Insurance Company Limited or its representative any and all information about me with reference to my health and medical history and any hospitalization, advice, diagnosis, treatment, disease or ailment. A photographic copy of this authorization shall be as valid as the original. The Insurance Company may ask you to be medically examined on the basis of the foregoing answers: If such is the case you must pay for such examination.

Signed at..... (city and country)

on this.....day of..... .....

.....
Signature of Proposed Insured Person

.....
Signature of Medical Examiner if Medically Examined

PART 2 — MEDICAL EXAMINER'S CONFIDENTIAL REPORT

How long have you known the Proposed Insured Person? Yrs.....Mo..... Are you related?.....

If the answer to any question is "Yes", identify question number and list complete details.

16 a. Height (In Shoes)	Weight (Clothed)	Males Only: Chest (Forced Expiration)	Chest (Full Inspiration)	Abdomen, at Umbilicus
fat. in. or cm.	lbs. or kilos.	in. or cm.	in. or cm.	in. or cm.

b. Did you weigh? [ ] Yes [ ] No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

17. Blood Pressure (if over 140 systolic or 90 diastolic, record 3 readings)

Systolic			
Diastolic (Disappearance of sound 5th phase)			

18. Pulse:

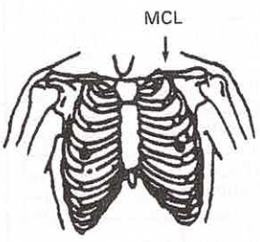
	AT REST	AFTER EXERCISE	3 MINUTES LATER
Rate			
Irregularities per min.			

19. Heart: Is there any:

Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below – If more than one, describe separately)

Location [ ] [ ]

			Indicate:
Constant	☐	☐	Apex by X
Inconstant	☐	☐	
Transmitted	☐	☐	Murmur area by ⌒
Localized	☐	☐	Point of greatest intensity by O
Systolic	☐	☐	
Presystolic	☐	☐	
Diastolic	☐	☐	Transmission by ▶
Soft (Gr. 1-2)	☐	☐	
Mod. (Gr. 3-4)	☐	☐	
Loud. (Gr. 5-6)	☐	☐	
After exercise:			
Increased	☐	☐	
Absent	☐	☐	
Unchanged	☐	☐	
Decreased	☐	☐	



For comments and your impression?

	Yes	No
20. Is there on examination any abnormality of the following: *(Circle applicable items and give details.)*		
(a) Eyes, ears, nose, mouth, pharynx? If vision or hearing markedly impaired, indicate degree and correction.)	[ ]	[ ]
(b) Skin; lymph nodes; varicose veins or peripheral arteries?	[ ]	[ ]
(c) Nervous system (include reflexes, gait, paralysis?	[ ]	[ ]
(d) Respiratory system?	[ ]	[ ]
(e) Abdomen (include scars)?	[ ]	[ ]
(f) Genitourinary system (include prostate)?	[ ]	[ ]
(g) Endocrine system (include thyroid and breasts)?	[ ]	[ ]
(h) Musculoskeletal system (include spine, joints, amputations, deformities)	[ ]	[ ]
21. Are there any hernias?	[ ]	[ ]
22. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	[ ]	[ ]