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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.

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

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

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?.....

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			

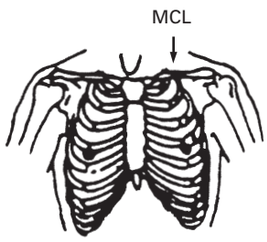
18. Pulse:	AT REST	AFTER EXERCISE	3 MINUTES LATER
Rate			
Irregularities per min.			

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?

20. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
(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)	[ ]	[ ]

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

23. Urinalysis	Specific Gravity	Albumin	Sugar

In addition to your analysis of the urine, send a portion to a qualified Laboratory if –

A. Requested by local office.

B. Applicant is over 60 years old.

C. Blood pressure is above 140 Systolic or 90 Diastolic.

D. Any urinary abnormality found or suspected.

E. There is any history of albumin or sugar, including family history of diabetes.

F. There are any findings or history of kidney, prostate, bladder or genito-urinary disease

Examination made:

At Applicant's place of business [ ] At.....A.M.

At Applicant's residence [ ]

At Examiner's office [ ] .....P.M.

On.....Day of..... .....

24. Do you know or suspect anything adverse about the proposed insured's health, character, mentality, habits or morals not otherwise covered above? Yes.....No.....
(A confidential report may be sent to the Medical Director)

.....

.....

.....

.....

Signature of Medical Examiner

.....

PLEASE PRINT: Name of Medical Examiner

.....

Address of Medical Examiner

.....

City and Country

.....

THE COMPLETION OF THIS FORM DOES NOT ENTITLE THE PROPOSED INSURED PERSON TO COVERAGE WHICH MUST FINALLY BE APPROVED BY THE INSURANCE COMPANY. IF APPROVED, COVERAGE WILL THEN COMMENCE ON THE FIRST DAY OF THE MONTH FOLLOWING SUCH APPROVAL.

INSTRUCTIONS TO THE MEDICAL EXAMINER

1. When an Examination is begun, the report thereof must not be suppressed or destroyed and must be sent directly to the Insurance Company regardless of your recommendation, fees are payable by the Proposed Insured Person .
2. An Examiner is not permitted to examine his own patients or relatives or cases for an agent who is a relative.
3. Any erasures or alterations in the statements made by the Proposed Insured Person must be initialled by him/her.
4. Any erasures or alterations in your report must be initialled by you.
5. The Medical Examiner's report must be recorded in your own handwriting.
6. If you are more familiar with the metric system, please use it but indicate that you are so doing.

IF THE ABOVE IS COMPLETED BY A DULY REGISTERED MEDICAL PRACTITIONER THEN DO NOT DETACH - MAIL ENTIRE FORM DIRECTLY TO THE OFFICE OF:

THE BEACON INSURANCE COMPANY LIMITED P.O. BOX 837, PORT OF SPAIN, TRINIDAD, W.I.

N.B.– Fees for examination are paid by the Proposed In-sured Person. This stub must be completed by the Medical Examiner in cases where the Proposed Insured Person is examined by him/her at the time of the exami-nation and mailed to the Company with the examination results without delay.

Full Name of Proposed insured Person.....

Name of Medical Examiner (print if applicable).....

Address of Medical Examiner (print if applicable).....

.....

Date.....