CLICO
[TRINIDAD] LIMITED
INSURANCE • PENSIONS • INVESTMENTS
A Member of the C L FINANCIAL GROUP

NON-MEDICAL
PART 11 OF APPLICATION FOR INSURANCE

POLICY NUMBER: ☐☐☐☐☐☐☐☐☐☐

HEAD OFFICE: 29 St. Vincent Street, Port of Spain, Republic of Trinidad and Tobago, W.I., Tel: (868) 623-1421, Fax: (868) 627-3821, Email: info@clico.com, Website: clico.com

Personal Declaration made in lieu of Medical Examination

PLEASE PRINT

1. (a) Name in full _____ (b) Marital Status _____

   (c) Occupation _____ (d) Height _____ (e) Weight _____

   (f) Has weight changed in the past two years? _____ (g) Loss _____ (h) Gain _____

   (i) Cause of weight change _____

   _____

   (j) Name and address of personal Physician (if none, so state) _____

   _____

   (k) Date of last consultation: _____ (l) Reason for last consultation: _____

   (m) Results of last consultation : _____

2. **Family history:**

   Have any of your family members had heart or kidney disease, blood disorder, diabetes, stroke, mental illness or any other hereditary disease? **YES** ☐ **NO** ☐

   Please complete the following:

	Age	State of health	Age at onset	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					
Spouse					
Children					

3. **Avocations, driving, lifestyle:**

During the past five years have you:	Answer "Yes" or "No"		If "Yes" give dates and full particulars
(a) flown, or do you contemplate making any flights other than as a fare paying passenger on a scheduled airline?	☐	☐	
(b) participated in any hazardous activities such as motor vehicle racing, parachute jumping, scuba diving, or is any such activity contemplated?	☐	☐	
(c) been convicted of two or more speeding violations or has your driver's licence been suspended?	☐	☐	
(d) been convicted of a criminal offence?	☐	☐	

4. **Travel**

   Do you intend to travel or have you travelled outside the Caribbean or North America for a period exceeding three months as indicated below?

   Name of country/ies _____

   Length of stay _____ Date travelled _____ Date returned _____

5. **Smoking**

   In the past 12 months have you smoked cigarettes, cigars, pipe or used any other form of tobacco or nicotine product? **YES** ☐ **NO** ☐

   If yes, please give details: type of tobacco _____

   amount smoked daily _____

6. Medical questions: Have you ever been treated for or had any known indication of:

		Answer "Yes" or "No"		If "Yes" give dates and full particulars
(a)	stroke, transient ischemic attack (TIA), dizziness, fainting, convulsions, headache, nervous breakdown, depression, epilepsy, multiple sclerosis or any other disorder of the brain or nervous system?	☐	☐	
(b)	high blood pressure, chest pain, angina, palpitations, heart attack, heart murmur, elevated cholesterol or any other disorder of the heart or blood vessels?	☐	☐	
(c)	asthma, bronchitis, tuberculosis, emphysema, blood spitting, persistent cough or any other disease or disorder of the lungs or respiratory system?	☐	☐	
(d)	colitis, intestinal bleeding or polyps, ulcer, recurrent indigestion, jaundice, hernia, hepatitis, or any other disease or disorder of the stomach, intestines, rectum, gallbladder, liver or pancreas?	☐	☐	
(e)	sugar, albumin, protein or blood in the urine, nephritis, kidney stones or cysts or any other disorder of the kidneys or bladder?	☐	☐	
(f)	diabetes, taken insulin or gone on a restricted or special diet?	☐	☐	
(g)	cancer, tumor or any other growth or malignancy, venereal disease, any disorder of the breast, prostate or other reproductive disorder?	☐	☐	
(h)	thyroid disorder, enlarged lymph glands, anemia, allergies or any other disorders of the blood or glands?	☐	☐	
(i)	any disorders of the eyes, ears, nose or throat?	☐	☐	
(j)	Rheumatoid arthritis, osteoarthritis or any chronic disorder of the joints?	☐	☐	
(k)	Disorder of the muscles or bones including spinal curvature (scoliosis)?	☐	☐	

7. (a) **Do you have or have you ever had:**

(i)	prolonged extreme fatigue for at least three (3) months?	☐	☐
(ii)	persistent fever or night sweats for at least three (3) months?	☐	☐
(iii)	significant weight loss unrelated to dieting of about 10% of body weight?	☐	☐
(iv)	hardening or swelling of the lymph glands in the neck, armpits or groin?	☐	☐
(v)	persistent diarrhoea?	☐	☐
(vi)	a heavy, persistent, often dry cough unrelated to smoking for at least three (3) months?	☐	☐
(vii)	a thick whitish coating on the tongue or in the throat?	☐	☐
(viii)	easy bruising or unexplained bleeding?	☐	☐
(ix)	recent, slowly enlarging purplish or discoloured lumps on top or beneath skin?	☐	☐
(x)	any recent blood transfusions?	☐	☐

(b) Do you belong to one of the following AIDS high-risk groups established by the health authorities:

(i)	Homesexual	☐	☐
(ii)	Bisexual	☐	☐
(iii)	Intravenous ((I. V.) drug users	☐	☐
(iv)	Haemophiliacs, or other users of blood products	☐	☐
(v)	Sexual partners of the preceding groups.	☐	☐

(c) Do you have or have you ever had AIDS, any other disorder of the immune system or test results indicating exposure to the AIDS virus (HIV positive)? ☐ ☐

		Answer "Yes" or "No"		If "Yes" give dates and full particulars
(d)	Have you ever been tested, received medical advice, counselling or treatment in connection with AIDS or an AIDS Related condition?	☐	☐	
	If yes, please give full details (routine testing for blood donation purposes may be ignored).			
(e)	Have you ever been tested, received medical advice or treatment in connection with any sexually transmitted disease including Hepatitis B?	☐	☐	

8. In the last 5 years, have you:

a.	had a check-up, consultation, illness, surgery, injury or disease not mentioned previously?	☐	☐	
b.	missed more than 15 consecutive days of work due to sickness or injury?	☐	☐	
c.	been a patient in hospital, clinic, sanatorium or other medical facility?	☐	☐	
d.	ever received or applied for a pension, disability benefit or compensation for accident, injury or illness?	☐	☐	
e.	had an ECG, X-ray, blood tests or other diagnostic tests?	☐	☐	
f.	been advised to have any tests, investigations or surgery which have not yet been undertaken or are you aware of any symptoms or complaints regarding your health for which you have not yet consulted a doctor or received treatment?	☐	☐	

9. Alcohol and drugs questions:

(a)	Do you drink alcoholic beverages?	☐	☐	
(b)	If yes, indicate the average number of drinks per week: _____			
(c)	Have you ever received treatment, been advised to receive treatment or joined an organisation because of your alcohol use?	☐	☐	
(d)	Have you ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug, including marijuana, cocaine or heroin?	☐	☐	
(e)	Are you now under observation or treatment or taking any prescribed medication?	☐	☐	
(f)	If yes, give details. _____			

10. Are you now in first class health and free from all symptoms of disease? ☐ ☐

11. Questions For Women ONLY: (If "Yes", give details)

(a)	Have you ever had any menstrual disorder or history of uterine or ovarian disease or menopause?	☐	☐	
(b)	Have you had any disease or tumour of breast?	☐	☐	
(c)	Have you had any abortion or miscarriage, any toxaemias of pregnancy, or difficulties in labour?	☐	☐	
(d)	Give date of last confinement. _____/_____/_____ (month / day / year)			
(e)	Are you now pregnant?	☐	☐	
	If so, give date of expected confinement _____/_____/_____ (Month / day / year)			

FOR GROUP INSURANCE

Was this examination made for Group Insurance?

YES ☐ No ☐

If Group Insurance complete this section:

Date of Birth: _____/_____/_____
month day year

Name of Employer: _____

Address _____

_____

Other reports completed (if any)

Micro-Urinalysis ☐ E.C.G. ☐ HIV ☐

Other _____

_____

_____

_____

_____

I have read all the statements and answers and they are complete and true. I understand that they shall form a part of the application to COLONIAL LIFE INSURANCE COMPANY (TRINIDAD) LIMITED for insurance to my life. To the extent permitted by the law, I expressively waive, in my name and that of any other person who shall have or claim an interest in any policy issued, reinstated, or changed as the result of these statements and answers, all provisions of the law forbidding any physician or other person who has attended or examined me or who may hereafter attend or examine me, from revealing any details or knowledge which was acquired thereby. I agree to be medically examined if the Company so requests.

Dated at _____ **this** _____ **day of** _____

Signature Proposed Life Insured: _____

Signature of Witness _____ **Agent** _____ **Agent Number** _____