Tatil
• TRINIDAD & TOBAGO INSURANCE LIMITED
• TATIL LIFE ASSURANCE LIMITED
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POLICY NO.:

TATIL LIFE
Guaranteed Protection

LIFE POLICY APPLICATION - PART 2
NON MEDICAL

1. PROPOSED LIFE INSURED please print	2. (a) DATE OF BIRTH	(b) AGE

3. HEIGHT	4. (a) WEIGHT - clothed	4. (b) ANY WEIGHT CHANGE IN THE PAST YEAR?	REASON
..... cms	..... kgs	☐ YES ☐ NO ☐ GAIN ..... kgs ☐ LOSS ..... kgs	.....

5. (a) NAME AND ADDRESS OF PERSONAL PHYSICIAN?
(If none, so state) .....

(b) DATE AND REASON LAST CONSULTED? .....

(c) TREATMENT, MEDICATION AND RESULTS? .....

6. HAVE YOU EVER BEEN TREATED FOR, COUNSELLED FOR, OR EVER HAD ANY KNOWN INDICATION OF:	**YES**	**NO**
(a) DISORDER OF EYES, EARS, NOSE OR THROAT?	☐	☐
(b) DIZZINESS, FAINTING, CONVULSIONS, EPILEPSY, HEADACHE, SPEECH DEFECT, MULTIPLE SCLEROSIS, PARALYSIS OR STROKE, MENTAL OR NERVOUS DISORDER, TRANSIENT ISCHEMIC ATTACK OR DEPRESSION?	☐	☐
(c) SHORTNESS OF BREATH, PERSISTENT HOARSENESS OR COUGH, BLOOD SPITTING, BRONCHITIS, PLEURISY, ASTHMA, EMPHYSEMA, TUBERCULOSIS OR CHRONIC RESPIRATORY DISORDER?	☐	☐
(d) CHEST PAIN, PALPITATION, HIGH BLOOD PRESSURE, CHOLESTEROL ELEVATION, RHEUMATIC FEVER, HEART MURMUR, HEART ATTACK, VARICOSE VEINS, PHLEBITIS OR OTHER DISORDER OF THE HEART OR BLOOD VESSELS?	☐	☐
(e) JAUNDICE, HEPATITIS, POLYPS OR INTESTINAL BLEEDING, APPENDICITIS, COLITIS, DIVERTICULITIS, CHRONIC DIARRHOEA. HEMORRHOIDS, RECURRENT INDIGESTION OR OTHER DISORDER OF STOMACH, INTESTINES, LIVER, GALL BLADDER OR PANCREAS?	☐	☐
(f) SUGAR, ALBUMIN, BLOOD OR PUS IN URINE, VENEREAL DISEASE, NEPHRITIS, STONE OR OTHER DISORDER OF KIDNEY, BLADDER, PROSTATE, BREAST, TESTES OR REPRODUCTIVE ORGANS?	☐	☐
(g) DIABETES, THYROID, OR OTHER ENDOCRINE DISORDERS?	☐	☐
(h) MOTOR NEURON DISEASE, INCLUDING AMYOTROPHIC LATERAL SCLEROSIS (ALS), NEURITIS, SCIATICA, RHEUMATISM, ARTHRITIS, GOUT OR DISORDER OF THE MUSCLES, NERVES OR BONES, INCLUDING THE SPINE, BACK OR JOINTS?	☐	☐
(I) DEFORMITY, LAMENESS OR AMPUTATION?	☐	☐
(j) DISORDER OF SKIN, LYMPH GLANDS, CYST, TUMOUR OR CANCER?	☐	☐
(k) ALLERGIES, ANAEMIA OR OTHER DISORDER OF THE BLOOD?	☐	☐
7. HAVE YOU EVER REQUESTED OR RECEIVED A PENSION, BENEFIT OR PAYMENT BECAUSE OF AN INJURY, SICKNESS OR DISABILITY?	☐	☐
8. HAVE YOU EVER HAD POLICE OR MILITARY SERVICE DEFERMENT, REJECTION OR DISCHARGE BECAUSE OF A PHYSICAL OR MENTAL CONDITION?	☐	☐
9. ARE YOU NOW UNDER OBSERVATION OR TAKING TREATMENT?	☐	☐

DETAILS OF YES ANSWERS:
Identify question number, circle applicable items, include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.

		YES	NO	DETAILS OF YES ANSWERS: Identify question number, circle applicable items, include diagnosis, dates, duration, and names and addresses of all attending physicians and medical facilities.
10.	**THE FOLLOWING QUESTIONS CONCERN ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS):**			
(a)	DO YOU BELONG TO ANY OF THESE GROUPS: HOMOSEXUALS. BISEXUALS, INTRAVENOUS DRUGS USERS. HEMOPHILIACS OR OTHER USERS OF BLOOD PRODUCTS, SEXUAL PARTNERS OF ANY OF THESE?	☐	☐	
(b)	HAVE YOU EVER SUFFERED FROM ENLARGEMENT OF THE LYMPH NODES (GLANDS), CHRONIC DIARRHOEA, CONTINUOUS FATIGUE, UNEXPLAINED WEIGHT LOSS. PERSISTENT NIGHT SWEATS. CHRONIC COUGH, UNUSUAL OR PERSISTENT LESIONS, OR UNEXPLAINED INFECTIONS?	☐	☐	
(c)	HAVE YOU EVER TESTED POSITIVE FOR HIV/AIDS OR ARE YOU AWAITING THE RESULTS OF SUCH A TEST?	☐	☐	
	HAVE YOU EVER BEEN TESTED OR RECEIVED MEDICAL ADVICE OR TREATMENT FOR AIDS OR AIDS RELATED CONDITIONS OR ANY SEXUALLY TRANSMITTED DISEASE, INCLUDING HEPATITIS B OR C, OR ANY OTHER IMMUNOLOGICAL DISORDERS?	☐	☐	
(d)	HAVE YOU EVER HAD A BLOOD TRANSFUSION OR USED BLOOD PRODUCTS?	☐	☐	
11.	**FEMALES ONLY:**			
(a)	HAVE YOU EVER HAD ANY DISORDER OF MENSTRUATION, PREGNANCY OR OF THE FEMALE ORGANS OR BREASTS?	☐	☐	
(b)	NUMBER OF CHILDREN BORN: ----------			
(c)	TO THE BEST OF YOUR KNOWLEDGE AND BELIEF ARE YOU NOW PREGNANT?	☐	☐	
	IF YES, GIVE NUMBER OF MONTHS ----------			
12.	**OTHER THAN PREVIOUSLY STATED HAVE YOU WITHIN THE PAST 5 YEARS:**			
(a)	HAD ANY MENTAL OR PHYSICAL DISORDER NOT LISTED ABOVE?	☐	☐	
(b)	HAD A CHECK-UP, EXAMINATION, CONSULTATION. ILLNESS. INJURY OR SURGERY?	☐	☐	
(c)	BEEN A PATIENT IN A CLINIC OR SANITORIUM OR OTHER MEDICAL FACILITY?	☐	☐	
(d)	HAD AN ELECTROCARDIOGRAM, X-RAY OR OTHER DIAGNOSTIC TESTS?	☐	☐	
(e)	BEEN ADVISED TO HAVE ANY DIAGNOSTIC TEST. HOSPITALIZATION OR SURGERY WHICH WAS NOT COMPLETED?	☐	☐	
13.	**FAMILY HISTORY: RE: YOUR PARENTS, BROTHERS AND SISTERS:**			**Give details including age of onset of all illnesses**
(a)	ANY HISTORY OF TUBERCULOSIS, DIABETES, CANCER. HIGH BLOOD PRESSURE, STROKE. HEART OR KIDNEY DISEASE, MULTIPLE SCLEROSIS, ALZHEIMERS, MOTOR NEURON DISEASE, MENTAL ILLNESS OR SUICIDE, OR OTHER FAMILIAL OR HEREDITARY DISEASES?	☐	☐	
(b)	ANY MEMBERS OF FAMILY DEAD? STATE WHO, AND GIVE AGE AT DEATH AND CAUSE OF DEATH.	☐	☐	
(c)	AGES IF ALIVE: FATHER ---------- MOTHER ----------			
	AGES /NUMBER OF: BROTHERS ---------- SISTERS ----------			
(d)	STATUS OF HEALTH OF LIVING PARENTS AND SIBLINGS AND AGE AT ONSET OF ANY ILLNESS:			

I DECLARE that the recorded answers to the questions in Parts 1 and 2 of this application are, to the best of my knowledge and belief, full, complete and true as of the date recorded and I agree that these satements and answers shall from part of my applications for insurance.

AUTHORIZATION (A photographic copy of this authorization shall be as valid as the original)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or any other organization or institution or person that has any records or knowledge of me or my health, or of my child or my child's health, to give to Tatil Life Assurance Limited any such information.

NOTE: A parent or legal guardian may sign on behalf of a minor by indicating relationship.

Dated at ---------- **this** ---------- **day of** ---------- **20** ----------

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Witness **Proposed Life Insured**