Application for Policy Change, Reinstatement, or Conversion for Health Policies

NAGICO INSURANCES
Fast, Fair & Always There | nagico.com

Policy # _____

Title**:** _____ Name: _____ D.O.B _____

Previous Name: _____ Place of Birth: _____ M ☐ F ☐

Residence Address: _____

Parish: _____ Country: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____ Mobile Phone: _____

Occupation: _____ E-mail address: _____

Employer: _____

☐ **SECTION A. POLICY CONVERSION**

Change current plan to **new plan** ☐

Maintain current deductible ☐ Yes ☐ No

If "No" and deductible decreases complete pages 2 - 6

New Premium $ _____ New Deductible $ _____

☐ **SECTION B. REDUCTION IN COVERAGE** requested

☐ Lifetime maximum to $ _____

☐ Increase deductible to $ _____

☐ New Premium $ _____

For sections A and B, complete, sign and date this page only.

☐ **SECTION C. POLICY CHANGE** requested; indicate type of change, sign and date below the complete pages 2- 6

☐ Increase the Lifetime maximum to $ _____

☐ Change the deductible from $ _____ to _____

☐ Add the following dependants _____

_____

☐ New Premium $ _____

☐ **Section D. POLICY REINSTATEMENT** requested; **sign and date below then complete pages 2-6**

_____ _____

Signature of Policy Owner Date: dd/mm/yyyy

_____

Signature of Witness

Application for Policy Change, Reinstatement, or Conversion for Health Policies

NAGICO INSURANCES
Fast, Fair & Always There | nagico.com

		Yes	No
1.	Are you now actively at work on a full time basis? (If "no" provide details on page 3)	☐	☐
	For the following questions, provide details to all yes answers on page 3		
2.	In the past twelve (12) months, have you used or smoked cigarillos (little cigars) cigars, pipe, shisha/hooka (water pipe), chewing tobacco, nicotine patch, Nicorette chewing gum or any other smoking cessation product, marijuana, hashish, betel nuts, snuff or tobacco in any form ?	☐	☐
3.	If you are currently a non-smoker, have you been a smoker in the past?	☐	☐
	If yes, when did you quit? _____		
	Why did you quit? _____		
4.	Have you travelled, resided or worked outside of Antigua & Barbuda in the past two (2) years, or do you intend to do so within the next two (2) years?	☐	☐
5.	Have you ever declared bankruptcy, personal or business, whether discharged or not?	☐	☐
6.	Have you ever had any application for health, disabilty, living benefits or critical illness insurance declined, rated, postponed, cancelled or modified in any way ?	☐	☐
7.	Have you ever applied for or received a pension, disability benefit or any compensation because of illness or injury?	☐	☐
8.	Have you ever engaged in hazardous activites such as Suba diving, sky diving, hang gliding, motorized vehicle racing, powerboat racing, mountain climbing, extreme sports, or flown as a private pilot, student pilot or crew member, or any other hazardous activities?	☐	☐
9.	In the past five (5) years, have you been charged with driving a vehicle while impaired or with reckless driving, had your drivr's license suspended or revoked, or have you had more than three (3) movin violations?	☐	☐
10.	Do you have any health or disability insurance in force, or do you have any application for health or disabilty insurance pending with any other company?	☐	☐
	If "Yes", provide name (s) of company(ies) and amount(s) applied for, on the next page.		
11.	In the past ten (10) years have you been convicted of any criminal offence, or are there any charges currently pending ?	☐	☐

12. Your build: Height _____ ft _____ in. or _____ cm Weight _____ lb. or _____ kg

13. Blood pressure: Systolic 1. _____ 2. _____ 3. _____

Further readings are to be taken at five-minute intervals

Diastolic 1. _____ 2. _____ 3. _____

		Yes	No
14.	Has your weight changed by more than ten (10) lbs/5.5kg in the past twelve (12) months?	☐	☐

If "Yes", provide amount of weight loss/gain, and reason below.

For all "Yes" answers to questions 2-13, proide dates and details below:

Questions #	Details

15 Provide name and address of your personal physician

Dr: _____

Address: _____

Date and reason last seen: _____

Results/Diagnosis/Treatment: _____

16. Provide your family health history. Under "condition', indicate any history of cancer, heart disease, stroke, diabetes, high blood pressure, kidney disease, or hereditary disorder. Age of onset refers to the age at which the diagnosis of the condition is made.

	Age of Living	Condition	Age Of Onset	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

17. **Since the date of the application for the original policy, have you had, been told you had, or received treatment or advice for:**

		Yes	No
a.	Disorder of the eyes, ears, nose or throat?	☐	☐
b.	Asthma, persistent cough or hoarseness, blood spitting, bronchitis, emphysema, tuberculosis, pneumonia, sleep apnoea, or other respiratory disorder?	☐	☐
c.	Dizziness, fainting, recurrent headaches, loss of consciousness, convulsions, paralysis, motor neuron disease, cerebral palsy, muscular dystrophy or other disorder of the nervous system?	☐	☐
d.	Chronic anxiety, chronic fatigue, depression or nervous breakdown?	☐	☐
e.	Hypertension or abnormal blood pressure, high cholesterol or blood lipids?	☐	☐
f.	Chest pain or discomfort, shortness of breath, stroke, transient ischemic attack (TIA), palpitations , heart attack, heart murmur, or any other problems with the heart, veins, or blood circulation?	☐	☐
g.	Ulcers, jaundice, gall bladder or liver disease, hepatitis, stomach or intestinal bleeding, chronic Diarrhoea or other disorder of the stomach or bowel?	☐	☐
h.	Sugar, albumin, blood or pus in the urine; kidney or bladder or urinary problems; venereal disease; or diseases of the breasts, prostate or reproductive organs?	☐	☐
i.	Amputation or congenital deformity; arthritis, or any sprain, strain, pain or disease of the back, Neck muscles, joints or spine?	☐	☐
j.	Diabetes, or any other disorder of the thyroid or any other endocrine glands?	☐	☐
k.	Any cyst, polyp, tumour, cancer, growth, or malignant disease?	☐	☐
l.	Acquired Immune Deficiency syndrome (AIDS), AIDS related Complex (ARC) Human Immunodeficiency Virus (HIV), or any other immunological disorder?	☐	☐
m.	Enlargement of the lymph nodes or glands, skin lesions, or unexplained infections?	☐	☐
n.	Lupus, anaemia, haemophilia, or any blood disorder?	☐	☐
o.	Undergone any surgical operation?	☐	☐
p.	Been advised to have any diagnostic test, treatment, hospitalization or surgery which has not yet been completed, or are you aware of any symptoms for which you have not yet consulted a physician?	☐	☐
q.	Other than already mentioned, in the past five (5) years have you consulted or been treated by any medical practitioners, or been admitted to the hospital or any treatment facility, or had any other known illness or abnormal test result ?	☐	☐

For all "Yes" answers to questions 16a – 16q, provide dates, treatment, medications, results, Names and addresses of physicians, hospitals and clinics.

Questions #	Details

		Yes	No
18.	Have you ever used a controlled substance or drug, other than as prescribed by a medical practitioner	☐	☐
19.	Do you drink alcohol?	☐	☐
	If "Yes", indicate quantities/units per week: Beer:_____ Wine:_____ Spirits: _____		
20.	Have you ever been advised to seek treatment for alcohol use?	☐	☐
	If "Yes", complete the Alcohol Usage Questionnaire.		

Application for Policy Change, Reinstatement, or Conversion for Health Policies

NAGICO INSURANCES
Fast, Fair & Always There | nagico.com

DECLARATIONS

The Policy Owner and Insured hereby declare that all statements and answers contained in this application are full, complete and true. This application, and the statements and answers in any document or questionnaire completed in connection with thus application shall form the basis of the policy.

The policy change or reinstatement applied for shall not take effect until it has been approved by Nagico Insurances, any policy amendments have completed and accepted by the owner, all outstanding premium has been paid, and there has been no change in insurability that would require different answers to any of the questions in this application form or related documents or questionnaires.

_____ _____

Signature of Insured Date: dd/mm/yyyy

_____

Signature of Policy Owner, if different than insured

_____

Signature of Parent or Guardian, if insured is under 18

AUTHORIZATION

I authorize and direct any physician, medical practitioner, hospital, clinic, laboratory, or other medical or medically related facility, insurance company, reinsurer, institution, investigative agencies, or person that now has or may in the future have any records of me or my health, to disclose to NAGICO Insurances, its authorized representatives, and its reinsurers, upon request of NAGICO Insurances, any such information deemed necessary by NAGICO Insurances for the purposes of underwriting, policy administration, claims investigation of misrepresentation or fraud.

I further authorize the performance of such examinations, x-rays, electrocardiograms, blood and urine profiles, and tests for HIV (AIDS) antibody and hepatitis needed to underwrite this application.

I authorize NAGICO Insurances to release the results of all examination and test results to my personal physician.

A photocopy of this authorization is as valid as the original.

_____

Print name of Insured

_____ _____

Signature of Insured Date: dd/mm/yyyy

_____

Signature of Parent or Guardian, if insured is under age of 18