CRITICAL ILLNESS INSURANCE APPLICATION FORM

APPLICANT

Name in Full: _____ D.O.B: _____ Sex: **O** Male **O** Female

Place of Birth: _____ Nationality: _____

Residential Address: _____ Postal Code: _____

Identification No: _____ Tel. No: _____ Cell No: _____

Height: _____ ft _____ in Weight: _____ lbs Weight gain/loss in past year: _____ lbs

Sum Insured: _____ Email: _____

PROPOSED OWNER (if the insured is the owner proceed to question 1)

Name in Full: _____ D.O.B: _____ Sex: **O** Male **O** Female

Residential Address: _____ Postal Code: _____

Occupation: _____ Relationship to the proposed insured: _____

Email: _____ Tel. No: _____ Cell No: _____

PROPOSED OWNER CORPORATION, TRUST OR OTHER ENTITY (if the insured is the owner proceed to question 1)

Name: _____

Title of person to whom all notices, statements and correspondence about this policy are to be sent: _____

Mailing Address (Street Name and Number): _____

City: _____ Country: _____ Postal Code: _____

Business No: _____ Email: _____

	Yes	No
1. Have you:		
a. Within the past three (3) years used any form of tobacco, marijuana, nicotine products or nicotine substitutes?	**O**	**O**
b. Ever been decline for life insurance or offered coverage at higher than standard rates?	**O**	**O**
c. In the last 10 years been charged with or convicted of any criminal offence?	**O**	**O**
d. Any condition for which medical consultation or treatment is contemplated or has been advised?	**O**	**O**
2. Have you ever consulted a physician, ever been treated for, or had any known indication of:		
a. Stroke (including transient ischemic attack), heart attack, coronary artery disease, severe valvular heart disease?	**O**	**O**
	O	**O**
b. Cancer/malignancy?	**O**	**O**
c. Advanced ophthalmic disease?	**O**	**O**
d. Multiple sclerosis or paralysis?		
e. Any chronic or progressive disease or disorder of the kidney, liver, pancreas or bone marrow that may lead to the failure of the organ or that may require transplantation?	**O**	**O**
	O	**O**
f. AIDS, HIV, chronic or unexplained infections?		
3. Within the last five (5) years have you ever had, been diagnosed with or had any known indication of a medical problem with respect to the following:		
a. Untreated or uncontrolled high blood pressure, heart murmur associated with known cardiac disease, or an abnormal ECG associated with the potential for or evidence of a cardiac event?	**O**	**O**
b. Diabetes, digestive or intestinal disorder, excluding functional disorder e.g. Irritable Bowel Syndrome?	**O**	**O**
c. Hospitalization due to a medical problem with respect to severe respiratory disorder?	**O**	**O**
d. Used habit forming drugs or received treatment or medical advice due to the use of drugs or alcohol?	**O**	**O**

	Yes	No
4. Have you ever sought advice or received treatment for, or had any known indication of:		
a. Advanced loss of hearing?	**O**	**O**
b. Alzheimer's disease, Parkinson's disease, motor neuron disease or other neuro-degenerative disorder?	**O**	**O**
5. Have any of your biological parents, brothers or sisters been diagnosed before age 65 with heart disease, stroke/TIA, cancer (including leukemia, lymphoma and Hodgins' disease), diabetes or Parkinson's disease?	**O**	**O**
6. Have you any physical impairments, deformities or illness not covered in questions?	**O**	**O**

7. If you have checked "Yes" to any question above, please provide complete information below.

Question No.	Dates/Duration	Treatment/Results	Names and full addresses of doctors and hospitals

8. Have you done any flying as pilot within the last two years? If yes, give details _____

9. Have you in the last 12 months:
   a. Participated in motorized racing, underwater diving, skydiving or any dangerous activity? **O** Yes **O** No
   b. Been declined, postponed, rated or restricted in any way? **O** Yes **O** No

10. Names and addresses of other physicians you have consulted within the last two years:

_____

_____

_____

Give dates and reasons for consultations and results: _____

_____

				If yes, give details
11. Have you ever had:	a. X-ray investigation?	**O** Yes	**O** No	_____
	b. An electrocardiogram	**O** Yes	**O** No	_____
	c. Blood or other special test?	**O** Yes	**O** No	_____

12. Are you now in good health? **O** Yes **O** No If no, give details _____

BENEFICIARY DESIGNATION

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to Insured: _____

Address of Beneficiary: _____

I HEREBY DECLARE all the recorded answers included above and on the reverse are, to the best of my knowledge and belief, full, complete and true as of this date.

A photographic copy of this authorization shall be as valid as the original.

I consent to NAGICO Insurances seeking medical information from any physician, medical practitioner, hospital clinic or other medical of medically related facility or organization who has at any time attended me, my spouse or children and I authorize that such information be given to NAGICO Insurances.

Dated this _____ day of _____ 20____

_____ _____

Applicant's Name & Signature Witness' Signature