STATE INSURANCE
COMPANY LIMITED

Live in a better State of mind
Redcliffe Street, P.O. Box 290, St. John's, Antigua. W.I.
(268) 481-7800/1/2/3/4 • info@sicantigua.com • sicantigua.com

APPLICATION FOR LIFE INSURANCE – PART I

1. PROPOSED INSURED ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Dr. ☐ Other _____

a) Name _____
Last First Initial

b) Address _____

c) Telephone _____ h) Occupation _____ Duties _____

d) Date of Birth _____ Employer _____
Day Month Year

e) Attained Age _____ f)Sex ☐ Male ☐ Female Address _____

g) Place of Birth _____ i) Approximate monthly Income _____

2. APPLICANT (OWNER) - If other than PROPOSED INSURED

a) Name _____
Last First Initial

b) Address _____

c) Relationship to proposed insured _____

3. INSURANCE APPLIED FOR

a) Plan _____ ☐ Par ☐ Non-Par b.) Enhancement Period ☐ None ☐ 20 ☐ 40 c.) Premium Quoted $_____

d.) Total Initial Amount _____ e.) ADD Amount _____ f.) Waiver of Premium ☐

g.) Mode of Payment ☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly h.) Method of Payment ☐ Cash ☐ Bankers Order ☐ Salary Deduction

4. BENEFICIARY/ ASSIGNMENT

a) Beneficiary(ies) 1.) _____ Relationship _____
2.) _____ Relationship _____
3.) _____ Relationship _____

b.) Is the right to change Beneficiary reserved? _____

c.) If accepted will the policy be assigned to any Bank or Financial Institution? _____

d.) If yes, give name of Bank or Financial Institution _____

5. INSURANCE HISTORY OF PROPOSED LIFE INSURED List all life or health insurance in force or pending

a)

Year Issued	*Pending*	*Company*	*Amount*	*AD/ADD Amount*	*Personal or Business*

b.) Has any Application for Insurance ever been declined, cancelled, postponed. If yes, provide specific company, date, and reason. _____

The proposed insured shall be the owner of any policy issued on this application unless another be named as owner thereof in the above. The undersigned declare(s) that all statements and answers in Parts I and II hereof are made a part of this application and that such all complete and true and correctly recorded. It is agreed that if this application is accepted the Company, the policy applied for herein together with this application, shall constitute the entire contract between the parties concerning the insurance therein provided. It also agreed that if no amount has been tendered to the Agent on the policy premium at the time of this application, such insurance shall not take effect until the application is approved and accepted by the Company at its Head Office and the policy is delivered while the Proposed Insured is in good health and the first premium thereon has been paid in full.

Dated at _____ this _____ day of _____ 20_____

Signed: _____
(Proposed Insured)

Witnessed: _____ Signed: _____
Applicant (If other than Proposed Insured)

RECEIPT

DO NOT DETACH UNLESS FULL FIRST PREMIUM IS PAID WITH APPLICATION

Received from _____

the sum of _____

for the full premium specified in the application for insurance, in the State Insurance Company Ltd., St. John's Antigua which bears the same date and serial number as this receipt. The insurance under the policy for which application is made shall be effective on date of this receipt on the date of completion of the medical examination (if required) whichever is the later date if, in the opinion of the authorized Officers of the Company at its Home Office in St. John's, Antigua the Proposed insured is insurable and accepted for insurance under its rules and practices on the plan of insurance, for the amount of insurance, and at the premium rate set forth in the application exclusive under its rules and practices on the plan of insurance, for the amount of insurance, and at the premium rate set forth in the application exclusive under its rules of any amendments in the space for "Home Office Additions or Corrections." However, if the Proposed insured dies prior to the Company's actual insurance and delivery of the policy applied for, the total liability Company declines to issue a policy or issues a policy other than the policy for which application is made, the Company shall incur no liability hereunder except to return by its check the above payment upon surrender of this receipt. This receipt shall be void if given for check or draft which is not honoured on presentation.

_____ 20 _____ Agent

If you do not receive your Policy or hear from the Company within 60 days, write us.

PART II - NON MEDICAL

Statements made in lieu of medical examination, in continuation of and as a part of application for policy in STATE INSURANCE COMPANY LIMITED, St. John's, Antigua.

1. Name/address of personal physician _____

   Date/reason last consulted _____ Number of years attended _____

   Any treatment or medication given, or recommended? _____ ☐ None

2. Height _____ Weight _____ Weight change in past year _____ ☐ None

   Reason for weight change _____

	YES	NO
3. Within the past 12 months, have you used any substance or product containing tobacco, nicotine or marijuana? If "YES" amount used daily	☐	☐
4. Within the last 5 years, have you engaged in or do you intend to engage in; flying (as a pilot, student pilot or crew member) motorized vehicle racing, parachuting, hand gliding, scuba diving or other hazardous sport, pursuit or avocation?	☐	☐
5. Have you ever been tested for, received treatment for, had any indication of or been told you had:		
a) Any disease or disorder of the respiratory system?	☐	☐
b) Chest pain, heart trouble or abnormal blood pressure?	☐	☐
c) Arthritis or rheumatism in any form?	☐	☐
d) Kidney disorder or diabetes or any eye disorder?	☐	☐
e) Any tumor, growth, cyst, or cancer in any form?	☐	☐
f) Any disease or disorder or the liver, pancreas, digestive system or nervous system?	☐	☐
g) AIDS (acquired immune deficiency syndrome) ARC (AIDS related complex), or any other immunological disorder?	☐	☐
h) Any enlargement or lymph nodes (glands), chronic diarrhea, unusual skin lesion, or unexplained infection?	☐	☐
6. Have you at any time been under observation, had medical or surgical advice or treatment, or been hospitalized for any disease or disorder not mentioned above?	☐	☐
7. Have you or any of your family members had heart disease, kidney disease, diabetes, cancer, stroke, mental illness or condition or any hereditary disease?	☐	☐
8. Do you drink alcoholic beverages? If "YES" indicate weekly quantity and type _____	☐	☐
9. Have you been treated for or received advice pertaining to your use of alcohol?	☐	☐
10. Have you used heroin, narcotics, barbiturates, psychoactive drugs, cocaine or similar agents?	☐	☐
11. Have you ever applied for or received a pension, disability benefit or compensation for any accident, sickness, or had any premiums waived under any insurance contract?	☐	☐
12. Are you now under observation or taking treatment?	☐	☐
13. Are you aware of any symptoms or complaints regarding your health, for which you have not yet consulted a physician or received treatment or has any treatment been recommended or scheduled which has not yet been completed?	☐	☐
14. Are there any outstanding changes against you or have you ever been convicted of a criminal offense? _____	☐	☐

Details of "YES" answers (identify questions and give full details including names & addresses of physicians, dates, duration, treatments and test results).

I have read the above answers and statements and declare that the same are true and complete.

Dated at _____ this _____ day of _____ 20 _____

Signature of Proposed Insured _____

Witnessed: _____ Agent: _____

AUTHORIZATION

I hereby authorize any licensed physician, Medical Practitioner, Hospital or Clinic or other Medical or Medically Related Facility, Insurance Company, or other Organization, Institution or person that has any record or knowledge of me or my health to give State Insurance Company Ltd. and its reinsures any such information. A photographic copy of this authorization shall be as valid as the original.

Signed: _____