Tatil
... where people are people

Application for Group Insurance
Evidence of Insurability
Part I

(Personal Declaration made in lieu of Medical Examination)

To be completed by Employer/Policyholder (*Mandatory for all applicants*)

1.a) Name Employer/Policyholder:_____

2.a) Full Name of Employee: _____

b) Residence of Employee: _____

c) Occupation: _____

d) Employee applying for Coverage for: **Self** ☐ **And/or Dependents** ☐

e) Coverage applied for: **Medical** ☐ **Life** ☐ **A.D.&D** ☐ **Critical Illness** ☐

f) Date employee considered first eligible for insurance: _____

g) Reason why coverage was not accepted at that time:_____

Reinstatement of coverage:
******To be completed by Employee*

h) Name and address of personal physician (s) for self and dependents (if none, so state): _____

i) Date and reason for last consultation for self and dependents: _____

j) Treatment, medication and results received or recommended: _____

k) Has weight changed in the last two years: Yes ☐ **No** ☐ **Loss:** _____ **lbs** **Gain:** _____**lbs**

l) Cause:_____

3. a) Complete Information for Yourself and/or Dependents:

I hereby make application for Health Insurance for Myself and/or the following Dependents.							
Give Full Name	**Relationship**	**Date of Birth**	**Sex**	**Weight**	**Height**	**Marital/Dependent Status (Please indicate)**	
	Employee	MM/DD/YY	M ☐ F ☐	☐ Lbs ☐ Kgs	☐ cm ☐ ft. in	☐ Single ☐ Married	☐ Divorced ☐ Other
	Spouse	MM/DD/YY	M ☐ F ☐	☐ Lbs ☐ Kgs	☐ cm ☐ ft. in	☐ Single ☐ Married	☐ Divorced ☐ Other
	Child	MM/DD/YY	M ☐ F ☐	☐ Lbs ☐ Kgs	☐ cm ☐ ft. in	☐ Single ☐ Married	☐ Employed
	Child	MM/DD/YY	M ☐ F ☐	☐ Lbs ☐ Kgs	☐ cm ☐ ft. in	☐ Single ☐ Married	☐ Employed
	Child	MM/DD/YY	M ☐ F ☐	☐ Lbs ☐ Kgs	☐ cm ☐ ft. in	☐ Single ☐ Married	☐ Employed

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b) In the table provided below, please state other Life, Health, or Critical Illness Insurance(s) in force.

Year Issued	Person Insured	Name of Insurance Company	Type of Coverage

Have you or any of your dependents:

	Employee	Spouse	Child
c) had any application for insurance pending with TATIL or any other company?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) ever had any application for insurance, change or reinstatement declined, postponed rated or modified in any way?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", to either question give details:

_____

4. Family History:

	Employee	Spouse	Child
Have you or any of your family members i.e., your Parents and Siblings had heart or kidney disease, blood disorder, diabetes, Stroke, mental illness, tuberculosis, high blood pressure, multiple sclerosis, Alzheimer's disease, Motor Neurone disease, or any other hereditary disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", please complete the following:

Relation	Age	State of Health	Age at onset	Age at Death	Cause of Death/Illness

5. Avocations, Driving, Lifestyle & Travel:

	Employee	Spouse	Child
a) During the past five years, have you or any of your dependents ever been convicted of a criminal offence?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Are you or any of your dependents a member of the military, naval air or police force or similar services?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Will you or any of your dependents be residing outside of Trinidad & Tobago for more than 185 consecutive days per calendar year?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", to any of the above questions give details

_____

_____

_____

_____

_____

_____

_____

_____

6. Medical Questions:

Have you or any of your dependents ever been treated for, or had any known indications of:	**Employee**	**Spouse**	**Child**
a) dizziness, fainting, convulsions, headache, nervous breakdown, depression, epilepsy, multiple sclerosis, or any other disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) stroke, transient ischemic attack (TIA), high blood pressure, chest pain, angina, palpitations, heart attack, heart murmur, elevated cholesterol, or any other disorder of the heart or blood vessel?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) asthma, bronchitis, tuberculosis, emphysema, blood spitting, persistent cough or any other disease or disorder of the lungs or respiratory system?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) colitis, intestinal bleeding or polyps, ulcer, recurrent indigestion, jaundice, hernia, hepatitis, or any other disease or disorder of the stomach, intestine, rectum, gallbladder, liver or pancreas?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) albumin, protein or blood in the urine, nephritis, kidney stones, or cysts, or any other disorder of the kidneys or bladder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) high blood sugar, diabetes, insulin resistance took insulin or gone on a restricted or special diet?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) venereal disease, any disorder of prostate or other reproductive disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) cancer, tumor or any other malignancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) thyroid disorder, enlarged lymph glands, anaemia, allergies, or any other disorders of the blood or glands?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) any disorders of the eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) rheumatoid arthritis, osteoarthritis, or any chronic disorder of the joints?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) disorder of the muscles or bones, including spinal curvature (scoliosis)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

7. Have you or any of your dependents :	**Employee**	**Spouse**	**Child**
Been tested/undergone or presently undergoing treatment/counselling for AIDS/HIV or any sexual transmitted disease or infection?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8. In the last five years, have you or any of your dependents:	**Employee**	**Spouse**	**Child**
a) had a check-up, consultation, illness, surgery, injury or disease not mentioned previously?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) missed more than 15 consecutive days of work due to sickness or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) been a patient in hospital, clinic, sanatorium, or other medical facility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) has an ECG, X-ray, blood test or other diagnostic test?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", give full details (routine testing for blood donation purposes may be ignored)

_____

9. COVID Questions:

	Employee	**Spouse**	**Child**
a) Have you or any of your dependents ever contracted COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", state most recent date contracted and date recovered:

_____

	Employee	**Spouse**	**Child**
b) Were you hospitalized because of COVID-19?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", state hospital and duration of stay and if any medication was

prescribed along with name of drug/s:

_____

c) Are you still currently experiencing covid related symptoms or have been diagnosed with long COVID? (these can include but are not limited to fatigue, shortness of breath, chest tightness or pain, joint or muscle pain, persistent cough, brain fog, changes in taste or smell)

Employee	Spouse	Child
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", give details, including any medication prescribed:

_____

10. Dental & Vision Questions:

Have you or any of your dependents have, or ever had:

Employee	Spouse	Child

a) been recommended/currently undergoing any treatment for or in relation to any dental procedures or dental diseases? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", please give details:

_____

b) been diagnosed with any vision related disorders or been recommended for any vision treatments for procedures? (which can include but are not limited to cataract, glaucoma, macular degeneration, diabetic retinopathy amblyopia.) ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", please give details:

_____

_____

11. Smoking:

In the past twelve months, have you or any of your dependents smoked cigarettes, cigars, pipe, or used any other form of tobacco or nicotine product? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", indicate amount smoked daily_____

12. Alcohol and Drugs:

Employee	Spouse	Child

a) Do you or any of your dependents drink alcoholic beverages? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", indicate the average number of drinks per week: _____

b) Have you or any of your dependents ever received treatment, been advised to receive treatment or joined an organization because of your alcohol use? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

c) Have you or any of your dependents ever used any sedative, stimulant, tranquilizer, hallucinogen, narcotic or other drug, including marijuana, cocaine or heroin? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

d) Are you or any of your dependents now under observation or treatment or taking any prescribed medication? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", give details:

_____

_____

_____

13. Questions for Women ONLY:

Employee	Spouse	Child

a) Have you or any of your dependents ever had any menstrual disorder or history of uterine or ovarian disease or menopause? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

b) Have you or any of your dependents had any disease or tumor of the breast? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

c) Have you or any of your dependents had any complication of pregnancy resulting in miscarriage or abortion? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

d) **If "Yes", give dates of last confinement: _____**MM/DD/YY_____

e) Are you or any of your dependents now pregnant? ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No

If "Yes", give expected date of delivery: _____MM/DD/YY_____

Details for questions 7 to 13. If any answer is "yes", give details. Use an additional sheet if necessary.							
Quest.#	**Name**	**Disease/Injury**	**Date**	**Duration**	**Nature of Treatment**	**Results**	**Name & Address of Physician and Hospitals**
			MM/DD/YY				
			MM/DD/YY				
			MM/DD/YY				
			MM/DD/YY				
			MM/DD/YY				
			MM/DD/YY				
			MM/DD/YY				

DECLARATION AND AUTHORISATION

I/We certify that I/We have read all the statements and to the best of my/our knowledge that the foregoing answers are true and correct.

I/We hereby authorise any physician, dentist or other practitioner, hospital, clinic, insurance company or any organisation, institutions or person that has any records or knowledge of me, my spouse or my children to give to Trinidad & Tobago Insurance Limited any and all information about me, my spouse or my children regarding conditions for which we have been previously under observation or treatment , including history, findings, pathology, diagnosis, and advice.
I further authorise that a photographic copy of this authorisation should be accepted as if such copy were the original authorisation.

I/We understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. I/We understand that failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I/We understand and agree that coverage shall not become effective until approved by Trinidad and Tobago Insurance Limited.

_____ *Date Completed*

_____ *Signature of Employee*

_____ *Signature of Spouse (if spouse is to be insured)*