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@siclfinancial.com • siclfinancial.com

Enrolment Form

PLEASE PRINT

POLICY NUMBER …… GROUP NUMBER……

EMPLOYER……

EMPLOYEE DETAILS

SURNAME …….. FIRST NAME …… INITIALS ……

POSITION/JOB TITLE …… NATIONALITY ……

MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH …… HEIGHT ……..IN WEIGHT ……..LBS

DATE OF EMPLOYMENT (DD/MM/YY) …… ANNUAL SALARY ……

SPOUSE'S NAME …… SPOUSE'S EMPLOYER ……

HOME MAILING ADDRESS ……

HOME PHONE …… MOBILE & EMAIL ……

BENEFICIARY NAME……

BENEFICIARY DATE OF BIRTH …… RELATIONSHIP ……

BENEFICIARY ADDRESS (IF DIFFERENT) (DD/MM/YY) ……

OFFICE USE ONLY

Initial & date

Approved for processing ……

Underwriting ……

PLAN ELECTION

Please complete if requesting benefits for yourself

MEDICAL HISTORY

Have you at any time been treated for or been told you had trouble with any of the following. Please answer YES or NO.
If you answer YES to any of the following questions, please give details on page 2 stating the relevant question number.

	YES	NO
1. HEART	☐	☐
2. HYPERTENSION, ABNORMAL BLOOD PRESSURE	☐	☐
3. CANCER, TUMOR, OR OTHER GROWTH	☐	☐
4. ALLERGIES	☐	☐
5. LUNGS, ASTHMA, BRONCHITIS, TUBERCULOSIS	☐	☐
6. DIABETES, GOITER, THYROID	☐	☐
7. KIDNEY STONES, KIDNEY PROBLEMS	☐	☐
8. ORTHO PROBLEMS (BACK,JOINT,ETC)	☐	☐
9. URINARY SYSTEM	☐	☐
10. NERVOUS-MENTAL DISORDER, NEUROLOGICAL DISORDER, CENTRAL NERVOUS SYSTEM	☐	☐
11. STOMACH / INTESTINES	☐	☐
12. HERNIA	☐	☐
13. HIV/AIDS OR AIDS RELATED	☐	☐
14. SUBSTANCE ABUSE (DRUGS OR ALCOHOL DEPENDENCY, ABUSE OR ADDICTION)	☐	☐

15. Have you any known physical impairment deformities or ill health not covered above? _____
16. Have you been examined by or consulted a doctor during the past three years? _____
17. Have you had any drug(s) prescribed during the past three years? _____
18. Have you been a patient in a hospital or similar institution during the past three years? _____
19. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so? _____
20. Have you been advised to have a surgical operation or procedure, but did not do so? _____
21. If female, are you pregnant? - If yes, what is your due date? _____
22. Do your dependent(s) have medical coverage with another company? _____
    If yes, please provide the name of the company…… Effective date……
23. Have you ever had an application for reinstatement of Life, Accident or Health Insurance declined, postponed, rated or modified?

Employee- Please complete if requesting benefits for your eligible dependents

DEPENDENT'S DETAILS FOR SPOUSE, CHILD(REN)

FULL NAME (Please Print)	SEX M/F	HEIGHT	WEIGHT	RELATIONSHIP	DATE OF BIRTH	EFFECTIVE DATE

DEPENDENT'S MEDICAL HISTORY

Have you at any time been treated for or been told you had trouble with any of the following. Please answer YES or NO.
If you answer YES to any of the following questions, please give details below.

	YES	NO		YES	NO		YES	NO
1. HEART	☐	☐	6. DIABETES, GOITER, THYROID	☐	☐	11. STOMACH / INTESTINES	☐	☐
2. HYPERTENSION, ABNORMAL BLOOD PRESSURE	☐	☐	7. KIDNEY STONES, KIDNEY PROBLEMS	☐	☐	12. HERNIA	☐	☐
3. CANCER, TUMOR, OR OTHER GROWTH	☐	☐	8. ORTHO PROBLEMS (BACK,JOINT,ETC)	☐	☐	13. HIV/AIDS OR AIDS RELATED	☐	☐
4. ALLERGIES	☐	☐	9. URINARY SYSTEM	☐	☐	14. SUBSTANCE ABUSE (DRUGS OR ALCOHOL DEPENDENCY, ABUSE OR ADDICTION)	☐	☐
5. LUNGS, ASTHMA, BRONCHITIS, TUBERCULOSIS	☐	☐	10. NERVOUS-MENTAL DISORDER, NEUROLOGICAL DISORDER, CENTRAL NERVOUS SYSTEM	☐	☐			

15. Have you any known physical impairment deformities or ill health not covered above? _____	☐	☐
16. Have you been examined by or consulted a doctor during the past three years? _____	☐	☐
17. Have you had any drug(s) prescribed during the past three years? _____	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years? _____	☐	☐
19. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so? _____	☐	☐
20. Have you been advised to have a surgical operation or procedure, but did not do so? _____	☐	☐
21. If female, are you pregnant? - If yes, what is your due date? _____	☐	☐
22. Do your dependent(s) have medical coverage with another company? _____	☐	☐
If yes, please provide the name of the company? …….. Effective date……..		
23. Have you ever had an application for reinstatement of Life, Accident or Health Insurance declined, postponed, rated or modified?	☐	☐

Details for questions answered yes

PRINT/NAME	QUESTION NO	DIAGNOSIS	MEDICATION TREATMENTS	CURRENT STATUS	NAME & ADDRESS OF PHYSICIAN
		Date Diagnosed_____		☐ ON- GOING ☐ COMPLETE RECOVERY	
		Date Diagnosed_____		☐ ON- GOING ☐ COMPLETE RECOVERY	
		Date Diagnosed_____		☐ ON- GOING ☐ COMPLETE RECOVERY	
		Date Diagnosed_____		☐ ON- GOING ☐ COMPLETE RECOVERY	
		Date Diagnosed_____		☐ ON- GOING ☐ COMPLETE RECOVERY	

DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any, from my pay. I also authorize any attending physician, surgeon, clinic hospital, the Medical Information Bureau or other organization, institution or person that has any records of knowledge of me or my health to give to State Insurance Company Ltd or as its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent on whom insurance is being requested. Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, State Insurance Company Ltd reserves the right to restrict or revoke cover.

EMPLOYEE'S/ INSURED'S SIGNATURE _____ DATE_____

EMPLOYER'S SIGNATURE _____ DATE_____