STATE INSURANCE
COMPANY LIMITED
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 FUNERAL GRANT

PART 1

Section 1: Proposed Life Insured

a) Name:

Title	*Last Name*	*First Name*	*Middle Name*

b) Date of Birth: (*Day* / *Month* / *Year*)

c) Place of Birth

d) Attained Age:

e) Sex: ☐ Male ☐ Female

f) Smoking status: ☐ Non-smoker ☐ Smoker

g) Home Address:

h) Telephone: Res. ( ) Bus. ( )

City: Country:

i) Employer:

k) Annual Income: $

j) Occupation:

l) Total Net Worth: $

Section 2: Applicant (Owner)

Complete this section only if the applicant (owner) is not the proposed life insured.

a) Name:

Title	*Last Name*	*First Name*	*Middle Name*

b) Date of Birth: (*Day* / *Month* / *Year*)

c) Place of Birth

d) Sex: ☐ Male ☐ Female

e) Smoking status: ☐ Non-smoker ☐ Smoker

f) Home Address:

g) Telephone: Res. ( ) Bus. ( )

City: Country:

h) Relationship to Proposed Life Insured:

Section 3: Beneficiary Information

a) Beneficiary:

Name	Relationship to Proposed Insured	Share (%)	Type *	Is Revocable? **
		%	☐ P ☐ C	☐ Yes ☐ No
		%	☐ P ☐ C	☐ Yes ☐ No
		%	☐ P ☐ C	☐ Yes ☐ No
		%	☐ P ☐ C	☐ Yes ☐ No

* P: Primary beneficiary; C: Contingent beneficiary.
** The beneficiary will be revocable unless otherwise specified.

b) If accepted, will the policy be assigned to any Bank or Financial Institution? ☐ Yes ☐ No

If yes, give name of Bank or Financial Institution: _____

Section 4: Coverage Details

a) Plan Name:

b) Sum Insured:
$

Section 5: Premium Payment

a) Payment Frequency:
☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

b) Method of Payment:
☐ Cash/Cheque ☐ Bankers Order ☐ Salary Deduction ☐ Pre-authorized Payment

c) Amount Paid with Application: $

Section 6: General Information

a) Existing funeral expenses insurance (complete details below): ☐ None

Name of Insurance Company	Date of Issue	Funeral Expenses Insurance Amount	
		$	
		$	
		$	

b) Have you had any company decline to issue or reinstate, rate, modify, postpone, rescind, or cancel any life insurance on your life? ☐ Yes ☐ No

c) Within the last two years, have you engaged in flying (as a pilot, student pilot or crew member), motorized vehicle racing, parachuting, hand-gliding, scuba-diving, or other hazardous activities; or intend to do so? ☐ Yes ☐ No

d) Have you had driving license suspended, revoked or been convicted of three or more moving violations in the past three years? ☐ Yes ☐ No

e) Have you ever been charged with or convicted of driving while impaired? ☐ Yes ☐ No

Section 6: General Information (Continued)

Please provide full details of all “Yes” answers for the above questions.

APPLICATION FOR FUNERAL GRANT

PART 2

Health Information

1. a) Name and address of personal physician?

_____

_____

_____

b) Date and reason of last visit?

_____

c) What treatment was given or medication prescribed?

_____

2. Height: ☐ ☐ft/in ☐cm Weight: ☐ ☐lbs ☐kg

3. Have you had or been medically advised to have an organ transplant, or have you been medically diagnosed as having a life expectancy of 12 months or less, or have you been diagnosed, treated (including dialysis) or taken medication for kidney or liver failure, or respiratory failure? ☐Yes ☐No

4. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)? ☐Yes ☐No

5. Have you ever had, been told you may have, received or been advised to receive treatment, medication or medical attention or testing for any disorder affecting the: ☐Yes ☐No

a) Cardiovascular system and blood such as: heart attack, stroke, T.I.A., leukemia, blood clot, high blood pressure, angina or chest pain, palpitations, heart murmur, shortness of breath, irregular heartbeat, high cholesterol, anaemia or any other disorder of the heart or blood vessels? ☐Yes ☐No

b) Respiratory system such as: asthma, emphysema, pneumonia, chronic bronchitis, chronic cough, persistent hoarseness, tuberculosis, pleurisy, or any other disorder of the respiratory system? ☐Yes ☐No

c) Gastrointestinal system such as: ulcer, colitis, Crohn's, hepatitis or hepatitis carrier state, jaundice, bleeding from the intestine or rectum, diarrhea lasting more than five days or any other disorder of the stomach, intestines, gall bladder, liver or pancreas? ☐Yes ☐No

d) Nervous system such as: burnout, psychiatric disorder, dizziness, convulsions, paralysis, fainting, epilepsy, Parkinson's Disease, Alzheimer's, chronic fatigue, anxiety, depression, multiple sclerosis, motor neuron disease, impairment of sight, hearing or speech or any other disorder of the brain or spinal cord? ☐Yes ☐No

e) Been medically diagnosed, treated or taken medication for diabetes, internal cancer, lymphoma, melanoma, leukemia, or systemic lupus (SLE)? ☐Yes ☐No

f) Had or been recommended to have treatment or counseling for alcohol or drug (morphine, cocaine or any narcotic drugs) use, or abused alcohol or drugs (morphine, cocaine or any narcotic drugs), or any diagnosed testing or surgery recommended by a medical professional which has not been completed or for which the results have not been received? ☐Yes ☐No

Please provide full details of all "Yes" answers for the above questions.

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Declaration, Agreements, Authorization and Signatures

The "Company" refers to State Insurance Company Limited. All correspondence with the Company may be sent to its Head Office.

Personal Information

To ensure the confidentiality of your personal information, the Company will establish a Life insurance file at its Head Office. It will contain all information obtained at the time of the application for insurance and of any insurance claim. The object of the file will be to enable the Company, and their respective agents to assess this application, administer any policy that may be issued, and appraise any risk or claim.

Only those employees authorized to have access to underwriting, administration and claims/legal review or any other persons whom you authorize, will have access to this file. You are entitled to access the personal information in this file and, if applicable, to rectify any inconsistencies. To do so, a written request must be sent to the attention of the access officer of the Company.

Declaration and Agreements

1. I am applying to the Company for the insurance described here and I declare and agree that:
   a) No person has authority to modify or waive any part of this Agreement.
   b) Acceptance of the policy constitutes approval of its provisions and ratification of any additions or endorsements or amendments.
   c) Coverage will begin when the policy is delivered to me while I am still in the same state of health as when coverage was applied for and the first premium has been paid to the Company
2. Any material misrepresentation will result in cancellation of the contract by the Company.

Pre-Authorized Payment

If the pre-authorized method of Payment is chosen, I authorize the Company to make withdrawals from the Owner's account designated to pay premiums or deposits (including those overdue). If premiums change for the insurance policy issued from this Application, the Company is authorized to amend the amount of the pre-authorized withdrawals. The pre-authorized payment plan will terminate if a cheque is not honoured by the financial institution. When terminated, the premiums for the policy will become payable annually unless an alternative payment method is elected in writing. The pre-authorized method of payment may be cancelled or changed by providing 10 days written notice to the Company.

AUTHORIZATION

I authorize any person or institution holding information of me personally, medically or financially, to provide this information to the Company for the risk assessment of my application or the investigation of any claim. I further consent to the release of this information to the Company's agent or duly appointed mandataries, and my personal attending physicians. In the event of death and upon request by the Company, the policyholder, beneficiary or estate administrator is expressly authorized to provide information to permit analysis and justification of the claim. A photocopy of this consent is as valid as the original. If required, I agree to provide additional signed copies of this consent.

I have read the entire contents of this application form and acknowledge that all statements and answers made in this application form, including Part 1, Part 2 and any supplementary applications or forms, are my true and complete statements and answers to the questions.

Signed at _____ This _____ day of _____ 20 _____

Signature of Proposed Life Insured: _____

Signature of Witness (Agent): _____

Signature of Applicant: _____