Branch Location:_____

Policy Number:
AMED 1

Taking Care of Your Medical Expenses.

APPLICATION FORM - ACCIDENTAL MEDICAL EXPENSES & DEATH

DETAILS OF THE PERSON PURCHASING AMED

Full Name:_____
(First Name) (Middle Initial) (Last Name)

Address:_____

Date of Birth: *DD/MM/YY* Sex : ☐ Male ☐ Female TRN:_____

Telephone: Home _____ Cell 1 _____ Cell 2 _____

Have you ever had any Personal Accident and/or sickness insurance declined or cancelled or renewal refused? ☐ Yes ☐ No

DETAILS OF THE PERSON REQUIRING COVERAGE

Full Name: _____
(First Name) (Middle Initial) (Last Name)

Date of Birth: *DD/MM/YY* Sex : ☐ Male ☐ Female TRN:_____

Does he or she live in Jamaica permanently? ☐ Yes ☐ No

What is his /her relationship to you:

☐ Self ☐ Mother ☐ Daughter ☐ Spouse ☐ Father
☐ Brother ☐ Son ☐ Sister Other _____

BENEFICIARY (person to claim in the event of death)

Full Name:_____
(First Name) (Middle Initial) (Last Name)

What is his/her relationship to you:

☐ Self ☐ Mother ☐ Daughter ☐ Spouse ☐ Father
☐ Brother ☐ Son ☐ Sister Other _____

Date of Birth: *DD/MM/YY* Sex : ☐ Male ☐ Female TRN:_____

Telephone:Home _____ Cell 1 _____ Cell 2 _____

Mailing Address:_____

YOUR DUTY OF DISCLOSURE

Before you enter into a contract of general insurance with an Insurer, you have a duty, under the **Law** to disclose to ***Us*** every matter that you know, or could reasonably be expected to know, is relevant to Our decision whether to accept the risk of the insurance and, if so, upon what terms. You have the same duty to disclose those matters to Us before you renew, extend, vary or reinstate a contract of insurance.

If you fail to comply with your duty of disclosure,We may be entitled to reduce Our liability under the contract in respect of a Claim or may cancel the Policy. If your non-disclosure is fraudulent, We may also have the option of avoiding the Policy from its beginning. It is therefore vital that you make sufficient enquiries BEFORE you complete your application form and BEFORE you sign any declaration for the information given. I hereby consent to the sharing of my information with the insurer or between the insurer and insured for insurance processing or claim settlement provided that such information will be treated as confidential and will not be shared with any third party without my written consent.

Signature: _____ **Date:** _____