

Group Health Insurance

NOTE: Please ensure that all the requested information on this application is provided. All incomplete applications will be returned to the applicant for more information. This will cause a delay in the process of enrolment. The information provided is treated as confidential.

PART 1 EMPLOYER DETAILS

Employer Name/No. _____
 Coverage SHIC Plus Provident Plan Premier Health Policy Number _____
 Street Address _____
 Mailing Address _____
 Tel. _____ Fax. _____ Email _____

PART 2 APPLICANT DETAILS

Surname _____ First Name _____ Middle Name _____
 Coverage Type Individual Group Applicant Only Applicant & Spouse Applicant & Child(ren) Family
 Gender Male Female Work Status Employed Self-Employed Unemployed Retired
 Position/Job Title _____ Effective Date of Coverage (DD/MM/YY) _____
 Annual Salary _____ Marital Status _____
 Date of Birth (DD/MM/YY) _____ Height ___ ft. ___ in. Weight ___ lbs. ___ oz. Immigration Status _____
 Home Address _____
 Mailing Address _____
 Telephone No(s) _____ Email _____

Beneficiary Name	Date of Birth (D/M/Y)	Tel. No.	Relationship	Address

PART 3a DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) Complete if requesting benefits for your eligible dependents

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth (DD/MM/YY)	Immigration Status
				Spouse		
				Child 1		
				Child 2		
				Child 3		

Is your spouse employed? Yes No If Yes: Name of Employer: _____
 Are medical benefits available from any other approved insurer to you/any of your named Dependents. Yes No
 If Yes, Approved Insurer: _____ Telephone: _____
 Has either you or any of your named Dependents had continuous coverage for a period of not less than one year? Yes No
 If Yes, Approved Insurer: _____ Telephone: _____

PART 4a MEDICAL HISTORY - APPLICANT AND DEPENDENT(S)

If you answer Yes to any of the following questions, please give details under Part 5 stating the relevant question number.

In the last 12 months, have you, or any of your dependents, been advised to receive, or received, medical consultation, care, treatment or taken medication in relation to any of the following?

- Heart or circulatory system (including but not Ltd. to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart. Yes No
- Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex) Yes No
- Neurological System (including but not Ltd. to convulsions, epilepsy, paralysis, Multiple Sclerosis, cerebral infarction(stroke), Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis Yes No
- Liver disorders (including but not Ltd. to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis Yes No

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- 5. Kidney/Renal disease or failure Yes No
 - 6. Cancer Yes No
 - 7. Diabetes (sugar) and/or Hypertension (high blood pressure) Yes No
 - 8. Respiratory conditions Yes No
 - 9. Organ Transplant Yes No
 - 10. Major surgery Yes No
- Are you or any of your dependents currently:
- 11. On medications? Yes No
 - 12. Pregnant (females only)? If Yes, please specify number of weeks gestation: Yes No
- Has any approved insurer within the last 12 months:
- 13. Declined an application for health insurance for you or any of your dependents? Yes No
 - 14. Required an increased premium or imposed special condition for you or any of your dependents? Yes No
 - 15. Cancelled or refused to renew an existing health insurance policy for you or any of your dependents? Yes No

PART 5 MEDICAL HISTORY DETAIL

If you have ticked Yes to any question in Part 4, please detail below. Use an additional sheet if necessary.

Patient Name	Ques. No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Physician Name & Address
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	

PART 6 DECLARATION

- a. I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.
- b. I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my (or my dependents') health records to release such information to British Caymanian Insurance Agencies Limited or Coralisle Medical Insurance Company Ltd. A photocopy of this signed authorization shall be as valid as the original.
- c. I understand and agree that any injury that occurred within twelve months 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. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.
- d. I understand and agree that coverage shall not become effective until accepted by the approved insurer.
- e. I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.
- f. I understand that this application will be valid for 30 days from the date of the signature.
- g. I understand and agree that failure to disclose relevant details or giving misleading information may cause my application to be deemed null and void.

Applicant Signature _____ Date _____

Employer Signature _____ Date _____

Internal Use Only	BMI <input type="checkbox"/>	Underwriting <input type="checkbox"/>	Approved for Processing <input type="checkbox"/>	Administrator <input type="checkbox"/>	Audit <input type="checkbox"/>	Plan Election	Other
Initial & Date							

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Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

British Caymanian Insurance Agencies Limited acts solely as an agent on behalf of Coralisle Medical Insurance Company Ltd.; it does not act as an insurance broker on behalf of its customers.

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PART 3b DEPENDENT(S) DETAILS Cont'd from Page 1 (Complete if requesting benefits for your eligible dependents)

If your employer has selected these optional extra benefits, please indicate if you also require these for your above-named Dependent(s).

Critical Illness: Self only Self + Spouse Self + Child(ren) Self + Family

Supplemental Accident*: Self only Self + Spouse Self + Child(ren) Self + Family *Ensure Beneficiary named on page 1

PART 4b SUPPLEMENTAL MEDICAL HISTORY - APPLICANT AND DEPENDENT(S)

Have you, or any of your Dependents, at any time, been treated for, or been told that you have trouble with, any of the following? Please tick YES or NO. If you answer YES to any of the following questions, please give details in Part 5.

	Employee		Dependent			Employee		Dependent	
	YES	NO	YES	NO		YES	NO	YES	NO
16. Thyroid, Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. Nervous-Mental Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Abnormal Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. Kidney Stones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Tumour or Other Growth.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. Urinary System/Reproductive System....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Stomach/Intestines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. Ortho Problems (Back, Joints, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Hernia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Lungs, Asthma, Bronchitis, Tuberculosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. Have you had any drug(s) prescribed during the past three years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Have you been a patient in a hospital or similar institution during the past three years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. Are you currently seeking any form of medical treatment, consulting with a physician or are you being advised to enter a hospital/institution for diagnosis, rest or treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Have you been examined by or consulted a doctor during the past three years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you been advised to have a surgical operation or procedure but did not do so?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33. Have you any known physical impairments, deformities or ill health not mentioned above?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you or your dependents ever had coverage with BritCay Insurance/Coralisle Medical Insurance?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please provide the name of the employer: _____ effective date: _____ and/or term date: _____				

PART 7 DECLARATION

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.

I understand and agree that any coverage will become effective following approval of the application by Coralisle Medical Insurance Company Ltd. ("the Insurer") which reserves the right to reject or accept any enrolment application.

Employee's Signature _____ Date _____

PART 8 STATEMENT OF GOOD HEALTH

If you have answered Yes to any questions in Part 4a and/or Part 4b for you and/or your Dependents, please ensure you have provided the relevant details in Part 5.

If you have answered No to all the questions in Part 4a and Part 4b for you and any Dependents, please complete and sign the Statement below.

I, _____, born on _____, affirm that I am of good health. I do not have any on-going medical conditions and I do not have any medical care, operations/surgery scheduled for the future.

I also confirm that my Dependent(s), listed in Part 3a of the Enrolment Form, are of good health and do not have any on-going medical conditions and do not have any medical care, operations/surgery scheduled for the future.

I understand that, should I misrepresent any information, Coralisle Medical Insurance Company Ltd. reserves the right to restrict or revoke cover.

Employee's Signature _____ Date _____

NOTE: You may on occasion be contacted by a company within the Coralisle Group Ltd. with offers/information in respect of other Group products. We confirm that only your contact details will be made available to Coralisle Group Ltd. personnel for such purposes and that your private information will not be transferred between Coralisle Group Ltd. companies or to any other third parties without your consent to do so. If you DO NOT wish to be contacted in this manner by Coralisle Group Ltd. personnel, please check here . Unless you check this box, we will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle Group Ltd. personnel for the Ltd. and specific purposes described above.