

Standard Health Insurance Contract

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. _____

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 _____

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 limited 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 limited 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 limited 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
- Kidney/Renal disease or failure Yes No
- Cancer Yes No
- Diabetes (sugar) and/or Hypertension (high blood pressure) Yes No

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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 _____

Dependent Signature _____ Date _____

Dependent Signature _____ Date _____

Employer Signature _____ Date _____

Internal Use Only Initial & Date	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

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Health Insurance and Employee Benefits

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A member of Coralisle Group Ltd.

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