CG | BRITCAY

GROUP INSURANCE APPLICATION

Health Insurance

This Application relates to: ☐ New Business ☐ Amendment to Existing Business*: Policy No._____

*Please complete only those Parts in which Amendments are being made.

PART 1 EMPLOYER DETAILS

Name of Organisation _____ CEO _____

Street Address _____

Mailing Address _____

Group Administrator _____ E-mail _____

Billing Contact: _____ E-mail _____

Phone No _____ Fax No. _____

☐ Monthly statement to be emailed. **Note:** Statements can be sent to up to 3 contacts. If desired, please advise 2 more recipients:

Email2 _____ Email3 _____

Agent _____ Broker _____

Type of Business _____ Requested Effective Date _____

Organisation Type ☐ Partnership ☐ Trust ☐ Foundation ☐ Charity ☐ Private Company ☐ Public Company

☐ Other Fund (specify): _____ ☐ Other (specify) _____

What other Coralisle Group Products do you have? ☐ Motor Insurance ☐ Home Insurance: ☐ Building ☐ Contents

☐ Travel Insurance ☐ Business Insurance ☐ Life Insurance: ☐ Group ☐ Individual

☐ Pension ☐ Medical Insurance ☐ Other _____

Total number of employees_____ Total number of dependents _____ Total number aged 65 years and over _____

Employer Contribution to Employee's coverage:_____ %* Employer Contribution to Dependent(s) coverage: _____ %

*NB: to be eligible for coverage, you must contribute an amount equal to at least 50% of the cost of the Employee Coverage for enrolled employees.

PART 2 TYPE OF COVER REQUESTED (please select and provide details for those benefits that you are applying for)

☐ Medical Plan Benefit: ☐ Premier Health ☐ Provident Plan ☐ SHIC Enhanced ☐ 125 ☐ 250 ☐ SHIC

☐ Dental Plan Benefit: ☐ Comprehensive ☐ Basic Effective Date: _____

☐ Vision Plan Benefit: ☐ Comprehensive ☐ Basic Effective Date: _____

☐ Life Benefit (Actual Salary* to be listed on supplied Spreadsheet)

Tier 1: Current Benefit (if any): _____

Requested Benefit: ☐ Flat Amount $ _____ OR ☐ Multiple of *Salary_____ Max Benefit _____

Tier 2: Current Benefit (if any): _____

Requested Benefit: ☐ Flat Amount $ _____ OR ☐ Multiple of *Salary_____ Max Benefit _____

☐ Supplemental Life Flat Amount $ _____

☐ Dependent Life ☐ Flat Amount Spouse $_____ ☐ Flat Amount Child $ _____

☐ Accidental Death and Dismemberment Benefit (AD&D) (Actual Salary* to be listed on supplied Spreadsheet)

Tier 1: Current Benefit (if any): _____

Requested Benefit: ☐ Flat Amount $ _____ OR ☐ Multiple of *Salary_____ Max Benefit _____

Tier 2: Current Benefit (if any): _____

Requested Benefit: ☐ Flat Amount $ _____ OR ☐ Multiple of *Salary_____ Max Benefit _____

☐ Short-Term Disability Benefit (Actual Salary* to be listed on supplied Spreadsheet)

☐ _____ % of *Salary ☐ Flat Amount - $ _____ ☐ Sickness - _____ Days

☐ Accident -_____ Days ☐ Maximum Amount - $_____ ☐ Maximum Period - _____

☐ Long-Term Disability (For this benefit, a separate info sheet will need to be completed)

☐ Critical Illness Benefit** Max. Benefit: ☐ $10,000 ☐ $25,000* ☐ $50,000*

☐ Supplemental Accident Benefit** ☐ with Disability ☐ without Disability

*Benefit amounts over $10,000 are subject to group size and industry classification. Please confirm with your sales representative.

**These Optional benefits will be Non-Voluntary (Company funded)

Health Insurance

PART 3 EFFECTIVE DATE OF COVERAGE

New employees are eligible to apply for coverage on the first day of their employment. Coverage is effective the first day of the month following completion of the medical underwriting process or the date of employment if there is no cover then in effect.

PART 4 IMPORTANT NOTE ABOUT MEDICAL UNDERWRITING

Employees of the enrolling Group must complete either a paper or online Employee Enrolment Form and answer health questions for themselves and all enrolling dependents. Everyone is subject to Medical Underwriting. This includes anyone with current Coralisle Medical Insurance Company Ltd. coverage. As a result of medical underwriting, applicants will: 1) be permitted to enrol without any medical exclusion; or 2) be permitted to enrol with an exclusion or limitation for a specific medical condition(s), including any complications or operations arising there from; or 3) be denied coverage entirely. If an employee is denied coverage due to medical underwriting, their family members may not enrol.

PART 5 EMPLOYEES TO BE COVERED

All employees under the age of 65 who are and have been continuously and actively in full-time employment and working no less than 30 hours per week, including or excluding those employees indicated below. Subcontractors and Consultants are not eligible.

- ☐ All retirees who have retired prior to the effective date of this coverage and who were covered under the group's prior health coverage regardless of their age.
- ☐ For employers with 100 or more employees, all employees (disabled after the effective date of this coverage) for a period of not more than 12 months.

The insurance which is being extended will automatically cease when the employee ceases to be an employee of the Policyholder or is no longer totally disabled unless the employee returns to being actively at work as an eligible employee in which case coverage will be continued if the premium continues to be paid.

*Only existing employees over age 65 who were covered under the Group's prior health coverage may enrol and enrolled employees who become 65 while covered under this Contract. This age limitation also applies to Dependents.

PART 6 MINIMUM ENROLLMENT REQUIREMENTS

If a group consists of less than 50 employees, 100% of the eligible employees must enrol and maintain enrolment. If a group consists of more than 50 employees, at least 75% of the eligible employees or at least 50 eligible employees, whichever is greater, must enrol and maintain enrolment. The Insurer reserves the right to inspect the records of the Group in order to verify the eligibility of employees and their dependents.

Total number of employees on Payroll or Pension Plan who at the time of this application have, for the preceding 6 months, been:

- ☐ Regular Full Time (working not less than 30 hours per week) for the last six months _____
- ☐ Part Time (working less than 30 hours per week) for the last six months _____
- ☐ Retired for the last six months _____
- ☐ Disabled for the last six months _____
- ☐ Total _____

Of the Total number of employees given above, please give number of affected employees and reason for them not enrolling:

- ☐ Retirees if not eligible _____
- ☐ Disabled if not eligible _____
- ☐ Employees who are covered through spouse's or parent's coverage _____
- ☐ Other: _____ _____

For all purposes of group eligibility, at least three people must be employed full-time and enrolled under the Group's coverage at all times. A husband and wife are considered as one person for purposes of group eligibility. No one may be enrolled under more than one identification number with Coralisle Medical, i.e., a husband and wife may not each have a separate family coverage. Enrolled groups which drop to one full-time employee for 90 days will be cancelled at that time or benefits reduced to the Standard Health Insurance Contract if comprehensive coverage is in place.

PART 7 GROUP CENSUS

Please use the separate Spreadsheet provided to submit your Group Census details.

Health Insurance

PART 8 DECLARATION

In connection with this application to Coralisle Medical Insurance Company Ltd., the applicant agrees and understands that:

a. Insurance on any individual shall not take effect until the effective date of the policy;
b. Insurance for which proof of insurability is required will not become effective until insurability is approved by Coralisle Medical;
c. Approval of insurance coverage is subject to our internal review procedures and the submission of all required documents.
d. Coralisle Medical reserves the right to restrict or revoke cover should any of the application or enrollment materials contain any misrepresentations;
e. The information contained in this application is, to the best of the applicant's knowledge, true and complete;
f. We hereby appoint British Caymanian Insurance Agencies Limited as our Agent of Record unless and until you are advised otherwise by us.
g. We hereby acknowledge that British Caymanian Insurance Agencies Limited acts solely as an agent on behalf of various insurers and it does not act as an insurance broker on our behalf.

I hereby, with my signature on this application, grant permission to British Caymanian Insurance Agencies Limited to verify this proposed credit application for accuracy and completeness.

Further, I grant my permission to British Caymanian Insurance Agencies Limited to seek, obtain and divulge any information regarding my credit history and credit account details or proposed dealings with you to or from any credit reporting bureau, any financial institution, my employer, or any other person in connection with any of my credit dealings with you; and I give same data controllers permission to divulge my information to you or any credit bureau.

I further understand that this credit information may be used to create and maintain a credit report file on my credit history and credit account details with any Cayman Islands credit reporting bureau, which may periodically receive credit updates from other financial institutions or creditors whom have extended credit to me and which may periodically divulge such credit information to members in good standing of such credit bureau.

CAUTION: Do not cancel your current coverage until after the medical underwriting results have been made known to you by Coralisle or your agent/broker.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

Coralisle is acting on behalf of itself, and not as agent for any other organisation, which has agreed to provide, in whole or in part, the benefits of any program listed hereon.

Following acceptance of this Application by Coralisle, a letter of receipt will be sent confirming rates based on actual enrollment. The Chief Executive Officer will be requested to initial rates and return them to Coralisle. Upon receipt, a Group contract will be issued to the Group. For existing Groups, an amendment, if required will be issued in the form of a separate Rider.

Subject to final approval by Coralisle Medical Insurance Company Ltd. Effective Date: _____

_____ _____

Sales, Health Insurance, British Caymanian Insurance Agencies Limited Date

_____ _____

Underwriting, Cayman, Coralisle Medical Insurance Company Ltd. Date

For office use only Group Insurance Number:

PART 9 NOTES/COMMENTS/QUESTIONS

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
PO Box 74, Grand Cayman, KY1-1102 Cayman Islands | Tel 345 949 8699 | Fax 345 945 0658 | www.CGCoralisle.com

Health Insurance and Employee Benefits

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A member of Coralisle Group Ltd.

Rev. 10-25

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.