CG | BRITCAY

EMPLOYEE ENROLMENT FORM

Cert. No. _____

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?

1. 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
2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex) ☐ Yes ☐ No

Group Health Insurance

3. 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
4. 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
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 ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

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.

Group Health Insurance

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.

Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan British Caymanian Insurance Agencies Limited may process any and all of the personal data provided.
- I consent to British Caymanian Insurance Agencies Limited processing my personal data, in accordance with British Caymanian Insurance Agencies Limited's Privacy Policy (https://international.cgcoralisle.com/privacy-policy/). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to British Caymanian Insurance Agencies Limited in respect of any third party, is done with that third party's consent and knowledge of British Caymanian Insurance Agencies Limited processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Applicant Signature _____ Date _____

Employer Signature _____ Date _____

Internal Use Only	BMI ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other
Initial & Date							

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

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

CG | BRITCAY

SUPPLEMENTAL ENROLMENT FORM & STATEMENT OF GOOD HEALTH

Group Health Insurance

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 Beneficiay 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 YES	Employee NO	Dependent YES	Dependent NO
16. Thyroid, Goiter	☐	☐	☐	☐
17. Nervous-Mental Disorder	☐	☐	☐	☐
18. Abnormal Blood Pressure	☐	☐	☐	☐
19. Kidney Stones	☐	☐	☐	☐
20. Tumour or Other Growth	☐	☐	☐	☐
21. Urinary System/Reproductive System	☐	☐	☐	☐
22. Stomach/Intestines	☐	☐	☐	☐
23. Ortho Problems (Back, Joints, etc.)	☐	☐	☐	☐
24. Hernia	☐	☐	☐	☐
25. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐	☐	☐
26. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	☐	☐
27. Have you had any drug(s) prescribed during the past three years?	☐	☐	☐	☐
28. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐	☐	☐
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?	☐	☐	☐	☐
30. Have you been examined by or consulted a doctor during the past three years?	☐	☐	☐	☐
31. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐	☐	☐
32. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐	☐	☐
33. Have you any known physical impairments, deformities or ill health not mentioned above?	☐	☐	☐	☐
34. Have you or your dependents ever had coverage with BritCay Insurance/Coralisle Medical Insurance?	☐	☐	☐	☐

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 _____