CG | BRITCAY

**EMPLOYEE ENROLMENT FORM**

Cert. No. _____

Policy No. _____

# 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 (DD/MM/YY) _____

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 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
2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex) ☐ Yes ☐ No
3. 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

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4. 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
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.

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.

# Standard Health Insurance Contract

## 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 _____

Dependent Signature _____ Date _____

Dependent 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.

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