

Health Insurance

PART 1 APPLICANT DETAILS

Company Name _____
 Mailing Address _____
 Contact Person _____ E.Mail _____
 Phone No. _____ Fax No. _____
 Total Number of Employees _____ Total Number of Dependents _____
 Type of Business _____ Effective Date (DD/MM/YY) _____
 Agent _____ Broker _____
 Previous Medical Client? Yes No If Yes, previous Policy No. _____ Cancellation Date (DD/MM/YY) _____

PART 2 TYPE OF COVER REQUESTED New Business Change Existing Business: Policy _____

PART 3 DETAILS OF COVER REQUESTED

- Medical Plan Benefit Premier Health Provident Plan SHIC Enhanced 125 250 SHIC (Basic)
- Dental Plan Benefit Comprehensive Basic
- Vision Plan Benefit Comprehensive Basic
- Life Benefit Flat Amount of \$ _____ OR Multiple of Salary = 1 2 3 4
- Supplemental Life Benefit Flat Amount of \$ _____
- Dependent Life Benefit Flat Amount Spouse \$ _____ Flat Amount Child \$ _____
- Accidental Death & Dismemberment Flat Amount \$ _____ OR Multiple of Salary = 1 2 3 4
- Short Term Disability Benefit 50% 60% 66.66% 70% of Weekly Salary to Max Amount \$ _____
- Long Term Disability Benefit 50% 60% 66.66% 70% of Weekly Salary to Max Amount \$ _____
 Waiting Period: 90 days 180 days
 Duration of Benefits: 2 yrs 5 yrs to age 65 RBD
- Critical Illness Benefit** Max Benefit Options: \$25,000 \$50,000
- Supplemental Accident Benefit**

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

PART 4 MEDICAL PROFILE

The following questions must be answered to the best of your knowledge for all employees and their dependents to be insured (proprietors, partners, corporate officers, employees, spouses, and dependent children.) The information in this Section is designed to assist in evaluating your Group. It is therefore essential that the information provided be complete and true to the best of your knowledge.

Please answer Yes or No giving details on questions to which you answer Yes in the space provided on the following pages.

- A. Has anyone been treated for, or shown symptoms of illness, or had surgery in the past five years? (e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness). Yes No
- B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past? (e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.) Yes No
- C. Has anyone had a claim of \$20,000 or more in the past 12 months? (Include copy of detailed claims reports if available.) Yes No
- D. Is anyone apt to have a continuing claim for a mental or physical disorder? Yes No
- E. Has anyone been advised to have surgery or diagnostic testing in the last six months or anticipate hospitalization for any other reason? Yes No
- F. Has any employee missed 10+ consecutive days of work in the past 12 months due to an illness or injury? Yes No
- G. Are there any spouses or dependents who are confined at home, incapacitated or confined in a hospital or treatment facility? Yes No
- H. Are there any employees who are not actively at work performing their duties full time, due to illness or injury? Yes No
- I. Are there any employees or dependent now not insured who have been declined for life or medical cover? Yes No

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PART 5 MEDICAL PROFILE DETAILS

Please complete the following section if you have answered 'Yes' to any of the questions on the previous page.

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

Patient Name: _____ **Patient Age:** _____ **Question Ref.** _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? Yes No

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Patient Name: _____ Patient Age: _____ Question Ref. _____
Diagnosis: _____
Treatment: _____
Prognosis: _____
Does the patient currently have insurance? Yes No

Patient Name: _____ Patient Age: _____ Question Ref. _____
Diagnosis: _____
Treatment: _____
Prognosis: _____
Does the patient currently have insurance? Yes No

Patient Name: _____ Patient Age: _____ Question Ref. _____
Diagnosis: _____
Treatment: _____
Prognosis: _____
Does the patient currently have insurance? Yes No

PART 6 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.

Client Name _____ Signature _____ Date _____

PART 6 COMMENTS/QUESTIONS

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
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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 7 GROUP CENSUS

No.	Gender	Date of Birth (DD/MM/YY)	Dependents*	Occupation	Annual Salary
1	<input type="checkbox"/> M <input type="checkbox"/> F				
2	<input type="checkbox"/> M <input type="checkbox"/> F				
3	<input type="checkbox"/> M <input type="checkbox"/> F				
4	<input type="checkbox"/> M <input type="checkbox"/> F				
5	<input type="checkbox"/> M <input type="checkbox"/> F				
6	<input type="checkbox"/> M <input type="checkbox"/> F				
7	<input type="checkbox"/> M <input type="checkbox"/> F				
8	<input type="checkbox"/> M <input type="checkbox"/> F				
9	<input type="checkbox"/> M <input type="checkbox"/> F				
10	<input type="checkbox"/> M <input type="checkbox"/> F				
11	<input type="checkbox"/> M <input type="checkbox"/> F				
12	<input type="checkbox"/> M <input type="checkbox"/> F				
13	<input type="checkbox"/> M <input type="checkbox"/> F				
14	<input type="checkbox"/> M <input type="checkbox"/> F				
15	<input type="checkbox"/> M <input type="checkbox"/> F				
16	<input type="checkbox"/> M <input type="checkbox"/> F				
17	<input type="checkbox"/> M <input type="checkbox"/> F				
18	<input type="checkbox"/> M <input type="checkbox"/> F				
19	<input type="checkbox"/> M <input type="checkbox"/> F				
20	<input type="checkbox"/> M <input type="checkbox"/> F				
21	<input type="checkbox"/> M <input type="checkbox"/> F				
22	<input type="checkbox"/> M <input type="checkbox"/> F				
23	<input type="checkbox"/> M <input type="checkbox"/> F				
24	<input type="checkbox"/> M <input type="checkbox"/> F				
25	<input type="checkbox"/> M <input type="checkbox"/> F				
26	<input type="checkbox"/> M <input type="checkbox"/> F				
27	<input type="checkbox"/> M <input type="checkbox"/> F				
28	<input type="checkbox"/> M <input type="checkbox"/> F				
29	<input type="checkbox"/> M <input type="checkbox"/> F				
30	<input type="checkbox"/> M <input type="checkbox"/> F				
31	<input type="checkbox"/> M <input type="checkbox"/> F				
32	<input type="checkbox"/> M <input type="checkbox"/> F				

* E = Employee only
 EE+SP = Employee and Spouse
 EE+C = Employee and Child(ren)
 F = Family