BRITCAY

Group Health Insurance

ENROLMENT FORM

Cert. No._____

NB: 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.

I EMPLOYER DETAILS

Employer Name/No. _____

Coverage ☐ SHIC Plus ☐ Provident Plan ☐ Premier Health Policy Number _____

Street Address _____

Mailing Address _____

Tel. _____ Fax. _____ Email _____

II 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 _____

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 _____ Telephone No. _____

Beneficiary Date of Birth (DD/MM/YY) _____ Relationship _____

Beneficiary Address (if different) _____

III DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) Please 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 or 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: _____

IV MEDICAL HISTORY - APPLICANT AND DEPENDENT(S)

If you answer Yes to any of the following questions, please give details under Section V 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
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

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

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

V MEDICAL HISTORY DETAIL If you have ticked Yes to any question in Section IV, please detail below. Use an additional sheet if necessary.

Patient Name	Question 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 ☐	

VI 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 Ltd. or Colonial Medical Insurance Co. 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 _____

Employer Signature _____ Date _____

NOTE: You may on occasion be contacted by a company within the Colonial Group with offers/information in respect of other Group products. We confirm that only your contact details will be made available to Colonial Group personnel for such purposes and that your private information will not be transferred between Colonial Group companies or to any other third parties without your consent to do so. If you **DO NOT** wish to be contacted in this manner by Colonial Group personnel, please check here ☐. Unless you check this box, we will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Colonial Group personnel for the limited and specific purposes described above.

BRITCAY

Group Health Insurance

SUPPLEMENTAL ENROLMENT FORM & STATEMENT OF GOOD HEALTH

III DEPENDENT(S) DETAILS Cont'd from Page 1 (Please 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 details are provided on page1

VII SUPPLEMENTAL MEDICAL HISTORY (If you answer YES to any of the following questions, please give details in Section V.)

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.

	Employee		Dependent	
	YES	NO	YES	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 British Caymanian Insurance/Colonial Medical Insurance?	☐	☐	☐	☐

If yes, please provide the name of the employer:_____effective date:_____ and/or term date:_____

VIII 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 Colonial Medical Insurance Company Limited ("the Insurer") which reserves the right to reject or accept any enrolment application.

Employee's Signature _____ Date_____

IX STATEMENT OF GOOD HEALTH

If you have answered Yes to any questions in Section IV or Section VII above for you and/or your Dependents, please ensure you have provided the relevant details in Section V.

If you have answered No to all the questions in Section IV and Section VII 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 Section III of the SHIC 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, Colonial Medical Insurance Company Limited reserves the right to restrict or revoke cover.

Employee's Signature _____ Date_____

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