BRITCAY

HealthInsurance

REQUEST FOR PROPOSAL

I 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) _____

II TYPE OF COVER REQUESTED ☐ New Business ☐ Change to Existing Buisness: Policy No._____

☐ Medical ☐ Dental ☐ Vision ☐ Life ☐ Accidental Death & Dismemberment ☐ Disability

III DETAILS OF COVER REQUESTED (indicate specific requirements for those items requested above)

Medical Plan Benefit ☐ Premier Health ☐ Provident Plan ☐ SHIC Enhanced ☐ 125 ☐ 250 ☐ SHIC Only (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 Benefit ☐ Flat Amount $_____ OR ☐ Multiple of Salary = ☐ 1 ☐ 2 ☐ 3 ☐ 4

Short Term Disability Benefit ☐ 50% ☐ 60% ☐ 66.66% ☐ 70% of Weekly Salary to a Maximum Amount of $_____

Long Term Disability Benefit ☐ 50% ☐ 60% ☐ 66.66% ☐ 70% of Monthly Salary to a Maximum Amount of $_____

Waiting Period: ☐ 90 days ☐ 180 days

Duration of Benefits: ☐ 2 yrs ☐ 5 yrs ☐ to age 65 ☐ RBD

IV 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.

Place answer Yes or No giving details on any questions to which you have answered 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 or more 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

V 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

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

VI COMMENTS

VII GROUP CENSUS

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

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