BRITCAY

# Standard Health Insurance Contract

**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. _____ 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 _____

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
5. Kidney/Renal disease or failure ☐ Yes ☐ No
6. Cancer ☐ Yes ☐ No

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

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 ☐ | |

## 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 Limited. or Colonial Medical Insurance Company Limited. 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 _____

Dependent Signature _____ Date _____

Dependent Signature _____ Date _____

Employer Signature _____ Date _____

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