CG / INS	UR/	ANCE				E ENROLMENT FO hange of Details O
		Premi	er Health			
PART 1 POLICY DETAILS	S (To be cor	mpleted by the	Employer)			
Group Name PolicyNo						
PART 2 EMPLOYEE/IND						
Surname			me			Initials
Position/Job Title Gender			tatus 🛛 Single	🗖 Marri	ed Divorce	d 🛛 Widowed
Date of Birth (DD/MM/YY)						
Date of Employment (DD/MM/Y						
Spouse's Name			Spouse's Emp	oloyer		
Home Mailing Address						
Tel. No(s)						
Beneficiary(ies) Name	DOB	Relationship	Ma	iling Addre	ess	Tel. No.
If naming more than one Benef	ficiary, % am	ounts must tota	al 100%. Contact	us to upo	date Beneficiary	y details at any time
If Beneficiary is under 18, pleas	e name a Gi	uardian/Trustee.	·			
PART 3 MEDICAL HISTO	RY - EMPLO	OYEE (Please of	complete if requ	uesting b	enefits for you	irself)
Have you at any time been trea		-		-	-	
If you answer YES to any of the	ese question YES N		etails in Section			
1. Heart	🛛 🖓		er	YES N	10	YES
 Heart Hypertension, Abnormal Blood Plant 		7. Thyroid, Goite		YES N	NO] 13. Nervous-Me	YES ental Disorder
2. Hypertension, Abnormal Blood P 3. Cancer, Tumour or Other Growth	ressure. 🛛 🗍	7. Thyroid, Goite 8. Kidney Stone 9. Urinary/Repro	s, Kidney Problems oductive System	YES N	IO] 13. Nervous-Me] 14. Neurologica] Nervous Dis	YES ental Disorder al Disorder, Central sorder
 2. Hypertension, Abnormal Blood Pl 3. Cancer, Tumour or Other Growth 4. Allergies 	ressure. □ □	7. Thyroid, Goite 8. Kidney Stone 9. Urinary/Repro 10. Ortho Proble	s, Kidney Problems oductive System ems (Back, Joints, e	YES N	NO 13. Nervous-Me 14. Neurologica Nervous Dis 15. HIV/Aids/Ai	YES ental Disorder al Disorder, Central sorder ds-related Disease
 2. Hypertension, Abnormal Blood Pr 3. Cancer, Tumour or Other Growth 4. Allergies 5. Lungs, Asthma, Bronchitis, Tubergies 	ressure.	7. Thyroid, Goite 8. Kidney Stone 9. Urinary/Repro 10. Ortho Proble 11. Stomach/Inte	s, Kidney Problems oductive System ems (Back, Joints, e estines	YES M	NO 13. Nervous-Me 14. Neurologica Nervous Dis 15. HIV/Aids/Ai 16. Substance A	YES ental Disorder al Disorder, Central sorder ds-related Disease Abuse (Drug or Alcoho
 2. Hypertension, Abnormal Blood Pr 3. Cancer, Tumour or Other Growth 4. Allergies 5. Lungs, Asthma, Bronchitis, Tubera 6. Diabetes 	ressure.	7. Thyroid, Goite 8. Kidney Stone 9. Urinary/Repro 10. Ortho Proble 11. Stomach/Inte 12. Hernia	s, Kidney Problems oductive System ems (Back, Joints, e estines	YES N	NO 13. Nervous-Me 14. Neurologica Nervous Dis 15. HIV/Aids/Ai 16. Substance A Dependency	YES ental Disorder
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Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date



EMPLOYEE ENROLMENT FORM

Premier Health

PART 5 MEDICAL HISTORY - DEPENDENT(S) (Please complete if requesting benefits for your eligible dependents) Have you at any time been treated for, or been told that you had trouble with, any of the following? Answer YES or NO. If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number. YES NO YES NO YES NO 2. Hypertension, Abnormal Blood Pressure . 4. Allergies...... 5. Lungs, Asthma, Bronchitis, Tuberculosis... 1 11. Stomach/Intestines....... 16. Substance Abuse (Drug or Alcohol 6. Diabetes...... Dependency, Abuse, Addiction)... D 17. Have you had any drug(s) prescribed during the past three years?..... 18. Have you been a patient in a hospital or similar institution during the past three years?..... 19. Have you been examined by or consulted a doctor during the past three years?...... 20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?...... 🔲 🗖 21. Have you been advised to have a surgical operation or procedure but did not do so?...... 22. Have you any known physical impairments, deformities or ill health not covered above?..... 23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?. 24. If female spouse, are you pregnant? - If yes, what is your due date? (DD/MM/YY)_____LMP date? _____. 🗆 🗖 25. Do you have medical coverage with another health insurer?..... If Yes, please provide the name of the health insurer ____ _____and effective date ____ 26. Have you ever had coverage with Coralisle Medical Insurance?..... If Yes, provide name of employer effective date and/or term date

PART 6 MEDICAL HISTORY DETAIL If you answered YES to any question in Part 3 or 5, please provide details here.

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 🗖	

PART 7	OPTIONA	L EXTF	RA BENE	FITS	Confirm	n with you	ir Employer	if these benefits	are	availab	le and	d under	what term	IS.
	 							_						

Critical Illness Supplemental Life Supplemental Accident (please ensure Beneficiary info is provided on page 1)

PART 8 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any, from my pay. I also authorize any attending physician, surgeon, clinic, hospital, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to Coralisle Insurance (BVI) Ltd. or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent for whom insurance is being requested. Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, Coralisle Insurance (BVI) Ltd. reserves the right to restrict or revoke cover.

Employee's Signature	 Date
Employer's Signature	Date

You may on occasion be contacted by a company within the Coralisle Group with offers/information in respect of other Coralisle products. We confirm that only your contact details will be made available to Coralisle Group personnel for such purposes and that your private information will not be transferred between Coralisle Group personnel, please check here \Box . Note that unless you check this box, Coralisle will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.

Coralisle Insurance (BVI) Ltd. Palm Grove House Town, Tortola, British Virgin Islands PO Box 2377, Road Town, Tortola VG1110, British Virgin Islands | Tel 284 444 8450 | www.CGCoralisle.com

Personal and Business Insurance, Health Insurance and Employee Benefits, Life Assurance

INSURANCE | HEALTH | PENSIONS | LIFE

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Rev. 07-24

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