CG | INSURANCE

EMPLOYEE ENROLMENT FORM

☐ Change of Details Only

Premier Health

PART 1 POLICY DETAILS (To be completed by the Employer)

Group Name ______________________ Plan Type ☐ Premier Health ☐ Provident Plan ☐ Island Plan

PolicyNo. ______________________ Certificate No. ______________________

PART 2 EMPLOYEE/INDIVIDUAL DETAILS

Surname ______________________ First Name ______________________ Initials __________

Position/Job Title ______________________

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (DD/MM/YY) ______________________ Height ________ft. ______ in. Weight _________lbs. _____ oz.

Date of Employment (DD/MM/YY) ______________________ Annual Salary ______________________

Spouse's Name ______________________ Spouse's Employer ______________________

Home Mailing Address ______________________

Tel. No(s) ______________________ Email ______________________

Beneficiary(ies) Name	DOB	Relationship	Mailing Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update Beneficiary details at any time.

If Beneficiary is under 18, please name a Guardian/Trustee. ______________________

PART 3 MEDICAL HISTORY - EMPLOYEE (Please complete if requesting benefits for yourself)

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 these questions, please give details in Section VI, stating the relevant question number.

	YES	NO		YES	NO		YES	NO
1. Heart	☐	☐	7. Thyroid, Goiter	☐	☐	13. Nervous-Mental Disorder	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐	8. Kidney Stones, Kidney Problems	☐	☐	14. Neurological Disorder, Central Nervous Disorder	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary/Reproductive System	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐			
6. Diabetes	☐	☐	12. Hernia	☐	☐			

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, are you pregnant? - If Yes, what is your due date? (DD/MM/YY) ______________ LMP date? ______________ ☐ ☐
25. Do you or your dependent(s) have medical coverage with another health insurer? ☐ ☐

    If Yes, please provide the name of the health insurer ______________________ and effective date __________

26. Have you or your dependents ever had coverage with Coralisle Medical Insurance? ☐ ☐

    If Yes, provide name of employer ______________________ effective date __________ and/or term. date __________

CG | INSURANCE

EMPLOYEE ENROLMENT FORM

☐ Change of Details Only

Premier Health

PART 4 DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) (Complete if requesting benefits for eligible dependents)

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

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
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
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 OPTIONAL EXTRA BENEFITS Confirm with your Employer if these benefits are available and under what terms.

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

Premier Health

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.

Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan Coralisle Insurance (BVI) Ltd. may process any and all of the personal data provided.
- I consent to Coralisle Insurance (BVI) Ltd. processing my personal data, in accordance with Coralisle Insurance (BVI) Ltd.'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 Coralisle Insurance (BVI) Ltd. in respect of any third party, is done with that third party's consent and knowledge of Coralisle Insurance (BVI) Ltd. 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.

Employee's Signature ______________________________ Date ______________

Employer's Signature ______________________________ Date ______________