CG | ATLANTIC MEDICAL & LIFE

GROUP INSURANCE APPLICATION

Premier Health

This Application relates to: ☐ New Business ☐ Amendment to Existing Business*: Policy No._____

*If requesting an Amendment to an existing Group Contract, please complete only those Parts in which the information is changing.

PART 1 EMPLOYER DETAILS

Company Name _____

VAT TIN _____ Business License No. _____

Mailing Address _____

Street Address _____

Contact Person - Billing _____ E-mail _____

☐ Monthly statement to be emailed. **Note**: Statements can be sent to up to 3 contacts. If desired, please advise 2 more recipients:

Email2 _____ Email3 _____

Contact Person - Admin. _____ E-mail _____

Phone No. _____ Fax No. _____

Agent _____ Broker _____

Type of Business _____ Effective Date (DD/MM/YY) _____

Organisation Type ☐ Partnership ☐ Trust ☐ Foundation ☐ Charity ☐ Private Company ☐ Public Company
☐ Other Fund (specify): _____ ☐ Other (specify) _____

Organisation Operations ☐ Local ☐ International ☐ Listed on stock exchange (which exchange?) _____

Description and Nature of the Business/Trust/Partnership etc. _____

_____

Organisation Website: _____

What other Coralisle Group Products do you have? ☐ Motor Insurance ☐ Home Insurance: ☐ Building ☐ Contents
☐ Travel Insurance ☐ Business Insurance ☐ Life Insurance: ☐ Group ☐ Individual
☐ Pension ☐ Medical Insurance ☐ Other _____

Total number of employees _____ Total number of dependents _____ Total number aged 65 years and over _____

PART 2 TYPE OF COVER REQUESTED

☐ Medical Plan Benefit ☐ Premier Health ☐ Provident Plan ☐ Self-Funded ☐ Deductible: $_____ ☐ OOP: $_____

☐ Dental Plan Benefit Effective Date: _____ ☐ Basic ☐ Comprehensive

☐ Vision Plan Benefit Effective Date: _____

☐ Life Benefit (Salary to be listed on Census) ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Dependent Life Benefit ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Supplemental Life Benefit

☐ Accidental Death & Dismemberment Benefit ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Short Term Disability Benefit ☐ ____ % of Salary ☐ Flat Amount $ _____ ☐ Sickness _____Days
☐ Accident:___ Days ☐ Maximum Amount $ _____ ☐ Maximum Period _____

☐ Long Term Disability Benefit
☐ _____ % of Salary ☐ Max Per Month - $ _____ ☐ Maximum Period _____
☐ Waiting Period _____ Days

☐ Critical Illness Benefit** Max. Benefit ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ Supplemental Accident Benefit**

** These Optional benefits will be: ☐ Voluntary (Employee funded) OR ☐ Non-Voluntary (Company funded)

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PART 3 DECLARATION

In connection with this application to Atlantic Medical Insurance Limited, the applicant agrees and understands that:

a. Insurance on any individual shall not take effect until the effective date of the policy;
b. Insurance for which proof of insurability is required will not become effective until insurability is approved by Atlantic Medical Insurance Limited;
c. Atlantic Medical Insurance Limited reserves the right to restrict or revoke cover should any of the application or enrollment materials contain any misrepresentations;
d. The information contained in this application is, to the best of the applicant's knowledge, true and complete;
e. The Agent/Broker whose name appears below is the applicant's Agent of Record.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

PART 4 AGENT/BROKER INFORMATION

Agent/Broker's Name: _____

Statement of Agent/Broker: I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted. To the best of my knowledge and belief, all statements in the Application for Group Insurance are true and complete. I have read and I understand the form.

Signature of Agent/Broker: _____ Date: _____

PART 5 SALES REPRSENTATIVE

Sales Representative Name: _____

Signature of Sales Representative: _____ Date: _____

PART 6 GROUP CENSUS

Please use the supplied spreadsheet to provide the Group's Census details.

PART 7 COMMENTS/QUESTIONS

Atlantic Medical Insurance Limited
Atlantic House, 2nd Terrace & Collins Avenue | PO Box SS-5915, Nassau, Bahamas | Tel 242 326 8191 | Fax 242 326 8189
Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442
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