



**Premier Health**

The information on this form 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.

**PART 1 EMPLOYER DETAILS**

Company Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Email \_\_\_\_\_  
 Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_  
 Agent \_\_\_\_\_ Broker \_\_\_\_\_  
 Type of Business \_\_\_\_\_ Effective Date (DD/MM/YY) \_\_\_\_\_  
 Current Carrier \_\_\_\_\_ Current Rates \_\_\_\_\_  
 Total number of employees \_\_\_\_\_ Total number of dependents \_\_\_\_\_ Total number aged 65 years and over \_\_\_\_\_  
 Previous Medical Client?  Yes  No If Yes, previous Policy No. \_\_\_\_\_ Cancellation Date (DD/MM/YY) \_\_\_\_\_

**PART 2 TYPE OF COVER REQUESTED**  New Business  Change Existing Business: Policy \_\_\_\_\_

**PART 3 DETAILS OF COVER REQUESTED (tick all that apply)**

Medical Plan Benefit  Deductible: \$ \_\_\_\_\_  OOP: \$ \_\_\_\_\_  
 Dental Plan Benefit  Basic  Comprehensive  
 Vision Plan Benefit  
 Life Benefit (Actual Salary To Be Listed On Census)  Flat Amount of \$ \_\_\_\_\_ or  Multiple of Salary \_\_\_\_\_  
 Dependent Life Benefit  Flat Amount of \$ \_\_\_\_\_ 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  Max Amount \$ \_\_\_\_\_  Maximum Period \_\_\_\_\_  
 Long Term Disability Benefit  
 \_\_\_\_\_ % of Salary  Max Per Month - \$ \_\_\_\_\_  Maximum Period - \_\_\_\_\_  
 Waiting Period \_\_\_\_\_ Days  
 Critical Illness Benefit\*\* Max. Benefit Options:  \$25,000  \$50,000  \$100,000  
 Supplemental Accident Benefit\*\*

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

**PART 4 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.)

Place tick Yes or No. Please give details on any questions answered Yes in the separate Census document.

- A. Has anyone been treated for, or shown symptoms of illness, or had surgery in the past five years?  Yes  No  
(e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness).
- B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past?  Yes  No  
(e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.)
- C. Has anyone had a claim of \$20,000 or more in the past 12 months?  Yes  No  
(Include a copy of detailed claims reports, if available.)
- 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



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- 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 other 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 dependents now not insured who have been declined for life or medical cover?  Yes  No

Please complete the following section if you have answered 'Yes' to any of the questions above. Please use an additional sheet if there are more persons with 'Yes' answers for the previous page.

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |

|   |              |                 |
|---|--------------|-----------------|
| Patient Name:   | Patient Age: | Question Ref. : |
| Diagnosis:  |              |                 |
| Treatment:  |              |                 |
| Prognosis:  |              |                 |
| Does the patient currently have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No |              |                 |



# ATLANTIC

MEDICAL & LIFE

## Premier Health

**PART 5** GROUP CENSUS

|    | Date of Birth<br>(DD/MM/YY) | Gender | Dependents | Annual Salary | Occupation/Title |
|----|-----------------------------|--------|------------|---------------|------------------|
| 1  |                             |        |            |               |                  |
| 2  |                             |        |            |               |                  |
| 3  |                             |        |            |               |                  |
| 4  |                             |        |            |               |                  |
| 5  |                             |        |            |               |                  |
| 6  |                             |        |            |               |                  |
| 7  |                             |        |            |               |                  |
| 8  |                             |        |            |               |                  |
| 9  |                             |        |            |               |                  |
| 10 |                             |        |            |               |                  |
| 11 |                             |        |            |               |                  |
| 12 |                             |        |            |               |                  |
| 13 |                             |        |            |               |                  |
| 14 |                             |        |            |               |                  |
| 15 |                             |        |            |               |                  |
| 16 |                             |        |            |               |                  |
| 17 |                             |        |            |               |                  |
| 18 |                             |        |            |               |                  |
| 19 |                             |        |            |               |                  |
| 20 |                             |        |            |               |                  |
| 21 |                             |        |            |               |                  |
| 22 |                             |        |            |               |                  |
| 23 |                             |        |            |               |                  |
| 24 |                             |        |            |               |                  |
| 25 |                             |        |            |               |                  |
| 26 |                             |        |            |               |                  |
| 27 |                             |        |            |               |                  |
| 28 |                             |        |            |               |                  |
| 29 |                             |        |            |               |                  |
| 30 |                             |        |            |               |                  |
| 31 |                             |        |            |               |                  |
| 32 |                             |        |            |               |                  |

Total number of employees \_\_\_\_\_ Total number of dependents \_\_\_\_\_ Total number aged 65 years and over \_\_\_\_\_

**CG Atlantic Medical & Life Insurance Ltd.**

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 Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442 |  
[www.CGCoralisle.com](http://www.CGCoralisle.com)

Health Insurance and Employee Benefits

**INSURANCE | HEALTH | PENSIONS | LIFE**

A member of Coralisle Group Ltd.