CG | ATLANTIC MEDICAL & LIFE

REQUEST FOR PROPOSAL

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 _____

PART 2 TYPE 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 3 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? (e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness). ☐ Yes ☐ No

B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past? (e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.) ☐ Yes ☐ No

C. Has anyone had a claim of $20,000 or more in the past 12 months? (Include a copy of detailed claims reports, if available.) ☐ Yes ☐ No

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

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

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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.

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Please complete an additional sheet if there are more persons with 'Yes' answers for the previous page.

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PART 4 GROUP CENSUS

	Date of Birth (DD/MM/YY)	Gender	Dependents	Annual Salary	Occupation/Title
1					
2					
3					
4					
5					
6					
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32					

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

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 |
www.CGCoralisle.com

Health Insurance and Employee Benefits

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