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ENROLMENT FORM

Solus Health

PART 1 PRIMARY INSURED'S DETAILS

Surname _____ First Name _____ Initials _____

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

Date of Birth (DD/MM/YY) _____ Height _____ft. ____ in. Weight _____lbs. ____ oz.

Position/Job Title _____ Employer _____

NIB No. _____ Country of Citizenship* _____

Residential Address _____

Mailing Address _____

Tel. No(s) _____ Email _____

Electronic Funds Transfer (EFT): Please supply the following Employee details in order to be reimbursed for any Claim payments.

Bank Name _____ Name on Bank Account _____

ABA Number _____ Bank Account No. (incl. Transit) _____

I (and my insured dependents) am ordinarily resident within The Bahamas (i.e. reside for 9 months+ per year) ☐ Yes ☐ No

*If Country of Citizenship is not The Bahamas, please provide proof of permission to reside in The Bahamas. ☐ Attached

PART 2 COVERAGE DETAILS

Coverage is for: ☐ Myself Only ☐ Myself plus my Spouse ☐ Myself plus my Child(ren) ☐ Myself plus my Family

Coverage Level: ☐ $500 Deductible ☐ $2,000 Deductible Life Insurance: ☐ $10,000 ☐ $25,000

Life Insurance Beneficiary(ies) Name	Date of Birth (DD/MM/YY)	Relationship	Mailing Address	Email 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. _____

Payment Option: ☐ Annual ☐ Semi-Annual ☐ Quarterly Requested Effective Date: _____

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 Part 6, 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		
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary/Reproductive System	☐	☐	Nervous Disorder	☐	☐
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐	16. Substance Abuse (Drug or Alcohol		
6. Diabetes	☐	☐	12. Hernia	☐	☐	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? ☐ ☐

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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? _____ ☐ ☐

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		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		
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary/Reproductive System	☐	☐	Nervous Disorder	☐	☐
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐	16. Substance Abuse (Drug or Alcohol		
6. Diabetes	☐	☐	12. Hernia	☐	☐	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? _____ ☐ ☐

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 ☐	
		Date Diagnosed:		On-going ☐	

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PART 7 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Premier Health individual plan from Atlantic Medical. I 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 ATLANTIC MEDICAL INSURANCE LIMITED 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 on whom insurance is being requested. Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, Atlantic Medical reserves the right to restrict or revoke cover.

Primary Insured's Signature _____ Date _____

Dependent Spouse's Signature _____ Date _____

Dependent Child's Signature (age 19+ only) _____ 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 companies or to any other third parties without your consent to do so. If you DO NOT wish to be contacted in this manner by Coralisle Group personnel, please check here ☐. 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 Group personnel for the limited and specific purposes described above.

Internal Use Only	BMI ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other
Initial & Date							

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, Bahamas | Tel 242 351 3960 | Fax 242 351 7442 | www.CGCoralisle.com
Health Insurance and Employee Benefits
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