

**PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED**

**SECTION I – PROSPECTIVE POLICYOWNER INFORMATION**

Prospective Policyowner			
Is this a subsidiary company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please state name of parent company:			
Mailing Address			
Current Business Address			
Type of Business			
Contact Person			Title
Business Phone	Cell	Fax	
Email Address			

Preferred Correspondence

- Cayman First Electronic Vault (Ask us for details!)     
  Post     
  Email

Previous/Current Health Insurance Carrier		
Previous/Current Health Insurance Policy ID	Effective Date (DD/MM/YYYY)	Termination Date (DD/MM/YYYY)
Reason for change (or proposed change) of carrier		

**SECTION II – INSURANCE COVERAGE**

Total number of employees	Requested effective date (DD/MM/YYYY)
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**A list of ALL employees must be submitted with this application.**

- The list should include:**
- Full name and date of birth of each employee
  - Full name and date of birth of each dependent to be covered

**GROUP LIFE AND DISABILITY INSURANCE IS AVAILABLE** (Please contact us for details).

<input type="checkbox"/> L030 Group Life only (Minimum 10 enrollees)	<input type="checkbox"/> L040 Group LifePlus (with AD&D) (Minimum 10 enrollees)	<input type="checkbox"/> Long Term Disability (Minimum 25 enrollees)
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**PLEASE FURNISH THE FOLLOWING CENSUS INFORMATION FOR THE MEMBERS TO BE INSURED**

AGE RANGE	NUMBER OF MEMBERS					Total
	Enrollee Only	Enrollee & 1 Child	Enrollee & 2 Children	Enrollee & Spouse	Enrollee & Family	
Less than 21						
21 – 35						
36 - 40						
41 - 45						
46 - 50						
51 - 55						
56 - 60						
61 - 65						
66 and over						

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**SECTION II Continued**

1. If replacing current or previous health insurance coverage, please provide the following historical information in reverse order, for the last three (3) years:

YEARS		TOTAL PREMIUM PAYMENTS (CIS)	TOTAL CLAIM PAYMENTS (CIS)	AVERAGE NO. OF ENROLLEES	MONTHLY PREMIUM RATES (CIS)		
From	To				Single	Couple	Family

(If necessary, please provide additional information on a separate page and attach it to this form)

2. Did the current or previous insurance carrier pay out more than CI\$5,000.00 in claims for any enrollee, dependent or incident over any two years? ....  Yes  No
3. Is that or any other insurance carrier currently making payments to or on behalf of any enrollee or dependent? .....  Yes  No
4. Is any enrollee or dependent now ill or pregnant?.....  Yes  No
5. If any of questions 2 through 4 have been answered with a "Yes", please provide the details here, or on a separate sheet, if necessary:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION III – APPLICANT’S CERTIFICATION**

**DECLARATION**

On behalf of the Applicant, I certify that the answers given are correct to the best of my knowledge, and I understand that this Application will form a part of the Health Insurance Policy when issued, and that any false statement made herein could result in withdrawal of coverage and cancellation of the subject Health Insurance Policy.

\_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_ Print Name of Applicant’s Representative \_\_\_\_\_ Signature

**(This form is valid for thirty (30) days after date of signature)**

**SECTION IV – TO BE COMPLETED BY BROKER (If applicable)**

\_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_ Name of Broker’s Representative \_\_\_\_\_ Signature

Broker’s Stamp

**SECTION V – FOR CAYMAN FIRST’S USE ONLY**

Underwriter’s comments \_\_\_\_\_

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