

PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED

Prospective Policyowner

SECTION I – APPLICANT INFORMATION

Prefix	Marital Status	Gender	Date of Birth DD/MM/YYYY	Height ft/m in/cm	Weight lb kg	IMMIGRATION STATUS	PREFERRED METHOD OF COMMUNICATION
<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Other _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower	<input type="checkbox"/> Male <input type="checkbox"/> Female				<input type="checkbox"/> Caymanian/ Status Holder <input type="checkbox"/> Work Permit Holder <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other _____	<input type="checkbox"/> Electronic Vault <input type="checkbox"/> Post <input type="checkbox"/> Email

Last Name	First Name	Middle Name
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Postal Address	Occupation	Date Employed (DD/MM/YYYY)
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Current Residential address

Email Address	Work Tel	Home Tel	Cellular	Fax
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- This confirms that no person named in my initial application has had any change in his/her state of health since I completed and signed that application.
- Since completing and signing the initial application, the following change(s) has (have) occurred in my (our) state(s) of health:

Please give details below:

Name of Insured/Dependent	Date of Diagnosis (DD/MM/YYYY)	Reason/Diagnosis	Treatment	Name, Address, Tel and Fax # of Medical Physician/Facility

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

DECLARATION AND AUTHORISATION

I (We) declare that to the best of my (our) knowledge and belief, the statements and answers given above are complete for all persons named in this enrollment application. I (We) understand that failure to disclose any information relevant to the issue of this insurance coverage may be deemed as material non-disclosure, and could result in the denial of claim payments, and the revocation of this coverage as at the effective date.

By completing and signing this form, I (we) hereby authorise Cayman First Insurance Company Limited, to obtain records on my (our) medical and other history from any physician; hospital; other medical provider; insurance company; employer, past or present; or any other source deemed necessary. A photocopy of this authorization may be used with the same authority as the original.

Applicant's Signature	Date (DD/MM/YYYY)	Spouse's Signature (if applicable)	Date (DD/MM/YYYY)
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(This form is valid for thirty (30) days after date of signature.)

SECTION II – VERIFICATION by Policyowner (If applicable)

I certify that this form was completed and signed in my presence, and that all the responses given are true and accurate to the best of my knowledge.

Health Plan Selection:	Requested Effective Date (DD/MM/YYYY)	Date (DD/MM/YYYY)	Print Name of Policyowner's Representative	Signature
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SECTION III – VERIFICATION by Broker (If applicable)

I certify that all the responses given are true and accurate to the best of my knowledge.

Date (DD/MM/YYYY)	Name of Broker's Representative	Signature
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Broker's Stamp

SECTION IV – FOR CAYMAN FIRST'S USE ONLY (Underwriter's acceptance)

Underwriter's comments:

Approval Stamp/Signature