

PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED

Employer		If subsidiary company, please state name of parent company here:			POLICY ID		
SECTION I – PROSPECTIVE ENROLLEE 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		
Postal Address				Occupation		Date Employed (DD/MM/YYYY)	
Current Residential address				Previous Residential Address			
Email Address				Cellular	Work Tel	Home	Fax
Current Insurance Carrier		Member ID		Effective Date (DD/MM/YYYY)		Est. Termination Date (DD/MM/YYYY)	Termination Reason
Previous Insurance Carrier		Member ID		Effective Date (DD/MM/YYYY)		Termination Date (DD/MM/YYYY)	Termination Reason
Name of <u>Local</u> Personal Physician			Address			Tel	
Name of <u>Overseas</u> Personal Physician			Address			Tel	
Beneficiary Name		Work Tel	Home Tel	Cellular	Address		Date of Birth (DD/MM/YYYY)
							Relationship

PLEASE PROVIDE THE REQUIRED INFORMATION ON DEPENDENTS TO BE COVERED (Dependents must reside in the Cayman Islands)
 (If necessary, please provide additional information on a separate page and attach it to this form)

Name	Date of Birth (DD/MM/YYYY)	Gender (M/F)	Relationship	Height ft/m in/cm	Weight lb kg	Current Employer (If applicable)	Current Health Insurance Carrier
1							
2							
3							
4							

	Name, Address, Telephone and Fax # of <u>Local</u> Personal Physician	Name, Address, Telephone and Fax # of <u>Overseas</u> Personal Physician
Dependent 1		
Dependent 2		
Dependent 3		
Dependent 4		

PLEASE ANSWER QUESTIONS 1 TO 8 FOR ALL PERSONS REQUESTING COVERAGE
 (If necessary, please provide additional information on a separate page and attach it to this form)

- Within the past twenty years, has any person named above

	Yes	No
a. Been hospitalized, had any surgical operation or diagnostic test (e.g. blood test, x-ray, mammography, or PSA)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been treated for heart disease, chest pains, high blood pressure, ulcerative colitis, kidney disorder, or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had any mental or nervous disorder, lung disorder, cancer, or tumors?	<input type="checkbox"/>	<input type="checkbox"/>
- Within the past ten years, has any person named above

a. Been attended, examined, tested, or had check up by any medical practitioner for any condition not listed above?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been advised to undergo medical treatment, mental or physical evaluation, or surgery, but has not yet done so?	<input type="checkbox"/>	<input type="checkbox"/>
c. Used hallucinatory, narcotic or other illegal, drug, or been treated or counselled for alcoholism?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had any life or health insurance modified, postponed, rated declined or renewal refused?	<input type="checkbox"/>	<input type="checkbox"/>
e. Made claims or received benefits on account of illness of injury?	<input type="checkbox"/>	<input type="checkbox"/>
- Is any person named above

a. Having any medical disease or defect or psychiatric illness?	<input type="checkbox"/>	<input type="checkbox"/>
b. Experiencing any symptoms of illness or poor health?	<input type="checkbox"/>	<input type="checkbox"/>

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SECTION I – Continued

4. Does any person named above currently participate or plan to participate in any hazardous sports? (Examples: auto, boat or motorcycle racing, mountain climbing, skiing, sky diving) Yes No
5. Has any person named above ever suffered from or was ever told that he (or she) had contracted Acquired Immune Deficiency Syndrome (AIDS), the Human Immunodeficiency Virus (HIV) virus or any form of sexually transmitted disease? Yes No
6. Is any person named above currently taking medications, suffering from any condition not previously mentioned or receiving any form of medical or psychiatric treatment? Yes No
7. Has any member of your immediate family (including spouse) ever been treated for tuberculosis, cancer, high blood pressure, heart or kidney disease, mental illness or AIDS? Yes No
8. a. Is any female named above currently pregnant? Yes No If yes, state the expected date of delivery: _____ (DD/MM/YYYY)
- b. State Last Menstrual Period (LMP) _____ (DD/MM/YYYY)
9. Where any Question 1 through 8 was answered with a "Yes", please provide details below:

Question No.	Name of Applicant/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)

10. Please provide information on your family history below:

APPLICANT'S FAMILY HISTORY	If living		If deceased			SPOUSE'S FAMILY HISTORY	If living		If deceased		
	Age	State of health	Age at Death	Cause	Year		Age	State of health	Age at Death	Cause	Year
Father						Father					
Mother						Mother					
Brother(s)						Brother(s)					
Sister(s)						Sister(s)					

(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 authorize 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) _____

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

SECTION II – VERIFICATION by Policyowner/Group Administrator

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) _____	Annual Salary of Applicant (if applying for Group Life &/or Disability) _____	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) _____	Print Name of Broker's Representative _____	Signature _____
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Broker's Stamp

SECTION IV – FOR CAYMAN FIRST'S USE ONLY

Underwriter's comments _____

Approved/Declined Stamp

TO BE COMPLETED BY POLICY RECORDS

Member ID	Plan Selection	Effective Date (DD/MM/YYYY)	Date entered in Plexis (DD/MM/YYYY)	Date ID card printed (DD/MM/YYYY)	Initials
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