BAF INSURANCE COMPANY
(CAYMAN) LTD.

GROUP ENROLLMENT FORM

AGENT: **EFFECTIVE DATE:**

Group Number	Employer	*P.O. Box::* City:		Phone #:	
Employee Name: Last First Initial		Sex	Salary	Marital Status	Hours per week
Employee Address:		Date Employed:		Job Duties:	
Beneficiary Name:	Relationship:	Address:			

Is your spouse employed? **Yes** ☐ **No** ☐

	Family Members Names List all family members (Last) First Middle	**Birthdate** DD/MM/YY	**Birthplace**	**Sex** M F	**Smoker** Y N	**Height** Ft : ins	**Weight** in lbs
Applicant				☐ ☐	☐ ☐		
Spouse				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		

Other Medical Benefits and Previous Health Insurance History:

Are Medical Benefits available for you, your spouse or any of your dependents from any other source? (e.g. Company, Insurer, Employer, Government or Association) Yes ☐ No ☐

If 'Yes' indicate source's name and telephone number:

In respect of you, your spouse or any of your dependents, has any insurer within the last 3 years:

a) Declined an application for Health Insurance? Yes ☐ No ☐

b) Required an increased premium or imposed special conditions? Yes ☐ No ☐

c) Cancelled or refused to renew an existing health policy? Yes ☐ No ☐

Note: It is expected that all members of the family will be enrolled under this policy, providing that they are insurable in accordance with BAF Insurance Company (Cayman) Limited's Underwriting Standards and that they are not already covered under another medical insurance plan, such as a group plan.

Signature of Applicant:_____ **Date:** _____

Health History Questionnaire – one form for each person to be insured

Name:_____ Date of Birth: _____

List previous health Insurance provider: _____

Questions I. To V. – please complete details to any 'yes' answers on back of form, including condition treated, care received, service dates, Doctor's name and address. (Circle disorder and tick squares).

	Yes	No
1. Has the person named above ever had or been treated for: a) Acquired Immune Deficiency Syndrome (AIDS), Chronic Pneumonia, Kaposi's Sarcoma, Heart Disorder, Cancer, Alcoholism or Alcohol Abuse, Drug use or Drug Addiction? b) Disease or disorder of the Urinary Tract, Digestive System, Reproductive System, Liver, Back, Bones or Joints? c) Diabetes, High Blood Pressure, Asthma, Chest Pain, Seizure disorder, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis or Blood disorder, elevated cholesterol level? d) Tumor or any other abnormal growth, Thyroid disorder, Paralysis, Arthritis, Nervous or Mental Disorder? e) Any other Physical disorder or deformity?		
11. Has the person named above had medical expenses exceeding $1,000 over the past 3 years?		
111. Has the person named above ever had or applied for Health Insurance (If Yes, please advise……..…..)		
1V. Is the person named above: a) Currently taking any prescribed medication or under medical treatment? b) Currently pregnant? c) Totally or Partially disabled?		
V. Within the last three years has the person named above: a) Consulted any doctor? (if yes, please specify……..……..) b) Been hospitalized or undergone medical studies? (If yes please specify…….) c) Received Medical treatment overseas? (if yes please provide details…….)		

VII. Name, Address and Telephone of the Personal/Family Physician of the person named above. If none so state:
Name:……..……
Address:……..…City:……..……
Country:……..…Tel:…….

VIII. Name, Address and telephone of any other doctor the person named above has seen in the last year. If none so state:
Name:…….
Address:…….City:……..……
Country:…….Tel:……..…….

If the person named above is less than 5 years old please provide the following information:
Was the child delivered at full term? Yes☐ No ☐ Were there any complications at birth? Yes ☐ No ☐
Method of childbirth? C- Section Vaginal delivery Weight at birth…….…..Current weight…….…….
Number of days in hospital after birth*?……
**If more than 5 days please provide full details on back of this form*

I UNDERSTAND THAT HEALTH INSURANCE BENEFITS MAY BE LIMITED OR EXCLUDED FOR CONDITIONS FOR WHICH A FAMILY MEMBER (INCLUDING MYSELF) HAS RECEIVED ANY MEDICAL DIAGNOSIS OR TREATMENT OR TAKEN ANY MEDICATION OR WHERE DISTINCT SYMPTOMS WERE EVIDENT PRIOR TO HIS OR HER EFFECTIVE DATE, ACCORDING TO THE PRE-EXISTING CONDITIOND LIMITATION PROVISIONS OF THE PLAN.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my children to give to BAF Insurance Company (Cayman) Ltd., or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness.

I UNDERSTAND the information obtained by use of the Authorization will be used by BAF Insurance Company (Cayman) Ltd., to determine eligibility for insurance and eligibility for benefits. **I ALSO AUTHORIZE BAF INSURANCE COMPANY (CAYMAN) LTD**. to release any information obtained to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I AGREE this Authorization shall be valid for two and one half years from the date shown below. **I KNOW** that I may request to receive a copy of this Authorization. I also acknowledge that I have read the **IMPORTANT NOTICES** on the reverse side. **I AGREE** that a photographic copy of this Authorization shall be as valid as the original.

APPLICANT'S SIGNATURE_____ **DATE**_____