APPLICATION FOR SHIC HEALTH INSURANCE

PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED

(Note: The information on this form is treated as confidential)

Check One:				**Agent Name:**	
□ Employed	□ Unemployed	□ Self Employed	□ Retired	Policy #:	Effective Date (MM/DD/YY)

SECTION A – APPLICANT INFORMATION

Last Name	**Date of Birth** (MM/DD/YY)	**Height** ft in	**Weight** lbs	**IMMIGRATION STATUS**
Middle Name				□ Caymanian/Status Holder
First Name				□ Work Permit Holder
				□Permanent Resident
				□ Other _____

Postal Address	**Current Residential Address**		
Email Address	**Sex: (M/F)**	**Cellular**	**Work Tel**
Beneficiary Name / **Date of Birth** (MM/DD/YY)	**Relationship**	**Postal Address**	**Telephone**

SECTION B – EMPLOYER INFORMATION

Name	**Signature**		
Email Address	**Office Telephone**		
Physical Address	**Postal Address**		
Current Insurance Carrier	**Policy ID**	**Effective Date** (MM/DD/YY)	**Est. Termination Date** (MM/DD/YY)

SECTION C – ELIGIBILE DEPENDENTS

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** (MM/DD/YY)	**Sex** (M/F)	**Relationship**	**Height** ft in	**Weight** lbs	**Current Employer** (if applicable)	**Employer's Current Health Insurance Carrier**	**Effective Date of Insurance** (MM/DD/YY)	**Immigration Status**

I. Are medical benefits available from any other approved insurer to any person listed above (Section A &/or Section C)?
□Yes □No
If yes, please provide the following information:
> > >

Dependent Name	**Approved Insurer**	**Effective Date** (MM/DD/YY)	**Telephone**

II. Has any person listed above (Section A &/or Section C) had continuous coverage for a period of less than one year?
□Yes □No
If yes, please provide the following information:
> > >

Dependent Name	**Approved Insurer**	**Effective Date** (MM/DD/YY)	**Telephone**

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SECTION D – MEDICAL QUESTIONNAIRE (MUST BE COMPLETED BY ALL PERSONS)	
(If necessary, please provide additional information on a separate page and attach it to this form)	
In the last twelve months has any persons listed above (Section A &/or Section C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:	
1. Heart or circulatory system (including but not limited to infraction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmia, disease of veins, arteries, or valves, stroke) and/or any other symptoms regarding circulatory system or heart.	□Yes □No
2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (Aids Related Complex).	□Yes □No
3. Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infraction (stroke), Alzheimer's disease, dementia) and /or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.	□Yes □No
4. Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which is referred to a doctor would result in a diagnosis.	□Yes □No
5. Kidney/Renal disease or failure.	□Yes □No
In the last twelve months has any person listed above (Part A & or Part C) ever:	
6. Been treated for cancer? If yes, please explain:	□Yes □No
7. Been treated for Diabetes (sugar), Hypertension (high blood pressure)? If yes, please explain	□Yes □No
8. Been treated for Respiratory conditions? If yes, please explain:	□Yes □No
9. Had an organ transplant? If yes please explain:	□Yes □No
10. Had major surgery? If yes, please explain:	□Yes □No
11. Are you currently on medications? If yes, please specify.	□Yes □No
12. Females only: Are you pregnant? If yes please specify the number of weeks gestation	□Yes □No
Has any approved insurer within the last twelve months:	
13. Declined an application for health insurance?	□Yes □No
14. Required an increased premium or imposed special condition?	□Yes □No
15. Cancelled or refused to renew an existing health insurance policy?	□Yes □No

DECLARATION AND AUTHORIZATION

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.
I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to BAF Insurance (Cayman) Limited. A photocopy of this signed authorization shall be valid as the original.
I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of the coverage.
I understand and agree that coverage shall not become effective until accepted by BAF Insurance (Cayman) Limited.
I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to BAF Insurance (Cayman) Limited.

_____	_____	_____	_____
Applicant's Signature	Date (MM/DD/YY)	Spouse's Signature	Date (MM/DD/YY)

THIS APPLICATION WILL BE VALID FOR THIRTY (30) DAYS FROM THE DATE OF SIGNATURE.
FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID

FOR BAF INSURANCE USE ONLY:	Comments