Cayman FIRST

APPLICATION FOR INDIVIDUAL HEALTH INSURANCE - SHIC

Form No. GIS34 Jul 4, 2018

RENEWAL DATE: JUNE 1, ANNUALLY

PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED
(Note: The information on this form is treated as confidential)
THIS APPLICATION WILL BE VALID FOR THIRTY (30) DAYS FROM THE DATE OF SIGNATURE

Check one:

☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired

SECTION A – APPLICANT INFORMATION

Last Name	Date of Birth DD/MM/YYYY	Gender Tick one	Height ft/m in/cm	Weight lb kg	IMMIGRATION STATUS
First Name		☐ Male ☐ Female			☐ Caymanian/ Status Holder ☐ Work Permit Holder ☐ Permanent Resident ☐ Other _____
Middle Name					

Postal Address	Current Residential Address

Occupation	Email Address	Cellular	Work Tel	Fax

Beneficiary Name	Date of Birth (DD/MM/YYYY)	Relationship	Postal Address	Telephone

SECTION B – EMPLOYER INFORMATION

Name	Email Address	Office Tel

Postal Address	Physical Address

Current Insurance Carrier	Policy ID	Effective Date (DD/MM/YYYY)	Est. Termination Date (DD/MM/YYYY)

SECTION C(i) – ELIGIBLE DEPENDENTS

I. Please provide the required information on dependents to be COVERED (Dependents must reside in the Cayman Islands)

Name	Date of Birth (DD/MM/YYYY)	Gender (M/F)	Relationship	Height Feet/inches	Weight Lbs/Oz	Current Employer (If applicable)	Employer's Current Health Insurance Carrier	Effective Date of Insurance	Immigration Status
1									
2									
3									

SECTION C(ii) – ELIGIBLE DEPENDENTS, INCLUDING APPLICANT

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

Name	Approved Insurer	Effective Date (DD/MM/YYYY)	Telephone

2. Has any person listed above, **including Applicant** (Section A &/or Section C) had continuous coverage for a period of not less than one year? ☐ Yes ☐ No
If yes, please provide the following information:

Name	Approved Insurer	Effective Date (DD/MM/YYYY)	Telephone

SECTION D – MEDICAL QUESTIONNAIRE - Please answer questions 1 to 15 for all persons requesting coverage

In the last twelve months has any person 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:

		Yes	No
1.	Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptoms regarding circulatory system or heart.	☐	☐
2.	Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immumo Deficiency Syndrome (AIDS) or ARC (AIDS related complex).	☐	☐
3.	Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction (stroke), Alzheimer's disease (dementia) and/or other symptoms 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 symptoms regarding the liver, which if referred to a doctor would result in a diagnosis.	☐	☐
5.	Kidney/Renal disease or failure.	☐	☐

In the last twelve months has any person listed above (Section A &/or Section C) ever:

6.	Been treated for Cancer?	☐	☐
7.	Been treated for Diabetes (sugar)/Hypertension (high blood pressure)?	☐	☐
8.	Been treated for Respiratory conditions?	☐	☐
9.	Had an organ transplant?	☐	☐
10.	Had major surgery?	☐	☐
11.	Are you currently on medications?	☐	☐
12.	Females only: Are you pregnant? If yes, please specify the number of weeks gestation _____ (Last LMP (DD/MM/YYYY)_____:	☐	☐

Has any approved insurer within the last twelve months:

13.	Declined an application for health insurance?	☐	☐
14.	Required an increased premium or imposed special conditions?	☐	☐
15.	Cancelled or refused to renew an existing health insurance policy?	☐	☐

16. Where any Question 1 through 15 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)

DECLARATION AND AUTHORISATION

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 Cayman First Insurance Company Limited.

A photocopy of this signed authorization shall be as 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 first 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 coverage.

I understand and agree that coverage shall not become effective until accepted by Cayman First Insurance.

I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.

Requested Effective Date (DD/MM/YYYY)	Applicant's Full Name	Applicant's Signature	Date (DD/MM/YYYY)	Spouse's Full Name	Spouse's Signature	Date (DD/MM/YYYY)

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID.

SECTION E – 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	Broker's Stamp

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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

To Whom It May Concern:

Your insurance cover includes coverage for insureds (primary insureds and/or dependents) under the policy. We collect and use relevant information about insureds to provide coverage and for mandated legal purposes. This information includes sensitive personal details including name, address and medical history.

We will process insureds' details, as well as any other personal information provided, in respect of your insurance coverage, in accordance with our Cayman First Insurance Data Protection Statement, a copy of which is available online at www.caymanfirst.com/dataprotectionstatment or upon request.

Please sign below acknowledging that you have read and understood the above statement:

Applicant Print Full Name	Signature	Date (DD/MM/YYYY)

Spouse (if spouse is being covered) Print Full Name	Signature	Date (DD/MM/YYYY)

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