CG | INSURANCE

ENROLMENT FORM

Solus Health

PART 1 PRIMARY INSURED'S DETAILS

Surname _____ First Name _____ Initials _____

Date of Birth (DD/MM/YY) _____ Height _____ in. Weight _____ lbs.

Position/Job Title _____ Male ☐ Female ☐

Country of Citizenship _____

Address _____

Home Phone _____ Cell Phone _____

Email (Work) _____ (Home) _____

PART 2 COVERAGE DETAILS

All selected Coverage is for: ☐ Myself Only ☐ Myself plus my Spouse ☐ Myself plus my Child(ren) ☐ Myself plus my Family

Selected Coverage Benefits: ☐ Major Medical ☐ Dental Insurance ☐ Vision Insurance

Payment Option: ☐ Annual ☐ Semi-Annual (plus 3% Service Fee) ☐ Quarterly (plus 6% Service Fee)

Effective Date 1st day of 20

*Beneficiary(ies) Name	Date of Birth	Relationship	Mailing Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update your Beneficiary details.

If a named Beneficiary is under 18, please name a Guardian/Trustee. _____

PART 3 MEDICAL HISTORY OF PRIMARY INSURED Please complete if requesting benefits for yourself

Have you at any time been treated for or been told that you had trouble with any of the following? Check YES or NO.

If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug/Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?	☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?	☐	☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY) _____ LMP date? _____	☐	☐
25. Do you or your dependent(s) have medical coverage with another health insurer?	☐	☐
If yes, please provide the name of the health insurer: _____ and effective date: _____		
26. Have you or your dependents ever had coverage with Coralisle Medical Insurance?	☐	☐
If yes, please provide the name of the employer _____ effective date _____ and/or term date _____		

PART 4 DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) Please complete if requesting benefits for your eligible dependents

Full Name (please print)	Address (if different from Insured)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

CG | INSURANCE

ENROLMENT FORM

Solus Health

PART 5 MEDICAL HISTORY OF DEPENDENT(S) Please complete if requesting benefits for your eligible dependents

Have you at any time been treated for or been told that you had trouble with any of the following? Please tick YES or NO
If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

	YES	NO		YES	NO		YES	NO
1. Heart	☐	☐	7. Thyroid, Goiter	☐	☐	13. Nervous-Mental Disorder	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐	8. Kidney Stones, Kidney Problems	☐	☐	14. Neurological Disorder, Central Nervous Disorder	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary/Reproductive System	☐	☐			
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐	16. Substance Abuse (Drug/Alcohol Dependency, Abuse, Addiction)	☐	☐
6. Diabetes	☐	☐	12. Hernia	☐	☐			

17. Have you had any drug(s) prescribed during the past three years? ☐ ☐
18. Have you been a patient in a hospital or similar institution during the past three years? ☐ ☐
19. Have you been examined by or consulted a doctor during the past three years? ☐ ☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so? ☐ ☐
21. Have you been advised to have a surgical operation or procedure but did not do so? ☐ ☐
22. Have you any known physical impairments, deformities or ill health not covered above? ☐ ☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified? ☐ ☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY)_____ LMP date?_____ ☐ ☐
25. Do you have medical coverage with another health insurer? ☐ ☐
If yes, please provide the name of the health insurer: _____ and effective date: _____
26. Have you ever had coverage with Coralisle Medical Insurance? ☐ ☐
If yes, please provide the name of the employer_____ effective date_____ and/or term date _____

PART 6 MEDICAL HISTORY DETAIL

Patient Name	Ques. No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Name & Address of Physician
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

PART 7 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Premier Health individual plan from Coralisle Medical. I authorize any attending physician, surgeon, clinic, hospital, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to CORALISLE MEDICAL INSURANCE COMPANY LIMITED or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent on whom insurance is being requested. I understand that my insurance will cease only at the end of the Premium Period and that there will be no pro-rata refund of premium. **Furthermore, I understand that should I non-disclose or misrepresent any information, either intentionally or negligently, for either myself or any dependents, Coralisle Medical reserves the right to restrict or revoke cover.**

Primary Insured's Signature _____ Date _____

You may on occasion be contacted by a company within the Coralisle Group with offers and/or information in respect of other Coralisle Group products. We confirm that only your contact details will be available to Coralisle Group personnel for such purposes and that your private information will not otherwise be transferred between Coralisle Group companies or to any other third parties without your consent to do so. If you **DO NOT** wish to be contacted in this manner by Coralisle Group personnel, please check here ☐. Note that unless you check this box, Coralisle will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda
PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

Rev. 08-20