HEALTH INSURANCE **APPLICATION**

Agent/Broker			MEDSAFE	
Policy Number			VPEN250	
Effective Date			NW 100	

Applicant's Name	Last Name	First Name	M.I.
Address	P.O. Box #	KY1-	Street & House Number
	City		Country
Telephone Number			
Email Address			
Marital Status	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow/Widower		
Nationality			

	Applicant	**Spouse**
Occupation		
Employer's Name		
Nature of Business		

	Family Members Names (only if dependent is being enrolled) Last First Middle	Birth Date (DD/MM/YYYY)	Birthplace	Sex M F	Smoker Yes No	Height Ft : Ins	Weight in lbs
Applicant				☐ ☐	☐ ☐		
Spouse				☐ ☐	☐ ☐		
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", please indication the source's name and telephone number.

In respect of you, your spouse and 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 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 should be completed for each person to be insured.

Name		Date of Birth	

Please list your previous health insurance provider	

		Yes	No
1	Has the person named above ever had or been treated for:	Yes	No
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?	☐	☐
d	Tumor or any other abnormal growth, Thyroid disorder, Paralysis, Arthritis, Nervous or Mental Disorder?	☐	☐
e	Any other Physical disorder or deformity?	☐	☐
f	Eye Disease?	☐	☐
2	Has the person named above had medical expenses exceeding $1,000 over the past three (3) years?	☐	☐
3	Has the person named above ever had or applied for Health Insurance? If "Yes", please advise	☐	☐
4	Is the person named above:		
a	Currently taking any prescribed medication or under medical treatment? If Yes please give the name of the prescription and the dosage below.	☐	☐
b	Currently pregnant?	☐	☐
c	Totally or partially disabled?	☐	☐
5	Within the last three years, has the person named above:		
a	Consulted any doctor? If Yes , please specify the name of the Doctor, date of visit and results below.	☐	☐
b	Been hospitalized or undergone medical studies? If, Yes , please specify the Diagnosis, date and results below.	☐	☐
c	Received Medical treatment overseas? If Yes , please specify the name of the Provider or Facility, date of Diagnosis and results below.	☐	☐

6 Name of the Personal/Family Physician of the person named above. If there is none, please state.

Name	
Specialty	Telephone Number:

7 Name of any other doctor the person named above has seen in the last year, If there is none, please state.

Name	
Specialty	Telephone Number:

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
Number of days in hospital after birth**:	Weight at birth:	Current weight:

APPLICANT'S AUTHORIZATION

I UNDERSTAND THAT HEALTH INSURANCE BEENFTS 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/HER EFFECTIVE DATE, ACCORDING TO THE PRE-EXISTING CONDITION 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 to or my children to give to **BAF Insurance Company (Cayman) Limited**, 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) Limited** to determine eligibility for insurance and eligibility for benefits. **I ALSO AUTHORIZE BAF INSURANCE COMPANY (CAYMAN) LIMITED** to release any information obtain 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.

Signature of Applicant		**Date**	

INDIVIDUAL HEALTH INSURANCE **ENROLLMENT**

TO:	**BAF Financial Insurance (Cayman) Limited** Health Department P.O. Box 10389 Grand Cayman KY1-1004 Cayman Islands

Date:	

FROM			
Employer Name:			
Full Address:			
Email Address:			
Telephone Number:			
P.O. Box:		**KY1#:**	

I/We wish to advise the following employee/s is/are employed by me and as such, I/we would appreciate if you could process the attached Health Insurance application/s.

Name of Employee	Date of Employment

Yours Truly,

Authorized Signature			
Print Name		**Title**	

Agent	