CAYMAN HEALTH INSURANCE APPLICATION [2024]

PLEASE NOTE THAT MULTIPLE INK COLORS, HANDWRITINGS OR A COMBINATION OF TYPED & HANDWRITTEN RESPONSES ARE NOT ACCEPTED. PRINT ALL WRITTEN RESPONSES IN ONE INK COLOR.

☐ New Application ☐ Dependent Addition(s) ☐ Change of Plan ☐ Conversion ☐ Re-application *(Non-refundable Processing Fee Applicable)*

Salesperson & No.		Policy Number		Effective Date	

A. APPLICANT'S INFORMATION

First Name		M.I.		Last Name	
Address	Postal Code			P. O. Box	
City				National ID #	
Telephone #s	Home			Mobile	
E-mail *(please print)*				Nationality	
Marital Status	☐ Single ☐ Married* ☐ Divorced* ☐ Widowed*			Former Last Name/nee: _____	

B. PLAN SELECTION

Please Select: ☐ Individual ☐ Group _____ (Company or Group Name)	☐ PRESTIGE	☐ VPEN 250	☐ MEDSAFE	☐ NW 100

C. IMMIGRATION STATUS (Provide details if necessary)

Primary Insured	☐ CAYMANIAN	☐ PERMANENT RESIDENT	DETAILS:
	☐ WORK PERMIT HOLDER	☐ OTHER	
Spouse	☐ CAYMANIAN	☐ PERMANENT RESIDENT	DETAILS:
	☐ WORK PERMIT HOLDER	☐ OTHER	

Family Members' Names *(Dependents must reside in The Cayman Islands)* First M.I. Last	State Relation	Birth Date (DD/MM/YYYY)	Place of Birth & Nationality	Sex M F	Smoker Yes No	Height Ft. Ins.	Weight lbs.
	Applicant			☐ ☐	☐ ☐		
	Spouse			☐ ☐	☐ ☐		
				☐ ☐	☐ ☐		
				☐ ☐	☐ ☐		
				☐ ☐	☐ ☐		
				☐ ☐	☐ ☐		

If this application includes dependents **between 19 & 24 years old;** are any of them a full-time student in a college or university ☐ Yes ☐ No ? If "Yes", please indicate the name of the college/university and provide proof (e.g. letter, document showing 12 or more credits) from the institution as evidence of full-time student status.

E. EMPLOYER'S INFORMATION (To be completed by Employer for Group Applicants)

Employer's Name		Employee's Title/Occupation	
P. O. Box		Date of Employment	
E-mail Address		Hours Worked/Salary	
Telephone Contact		**Authorized Signature**	

F. CURRENT/PRIOR COVERAGE INFORMATION

Are Medical Benefits available for you, your spouse or any of your dependents from other source? (e.g. Company, Insurer, Employment, Government or Association) ☐ Yes ☐ No. If "Yes", please indicate the source's name, address and number.

F. CURRENT/PRIOR COVERAGE INFORMATION cont'd...

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 or Life 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

If the answer is "Yes" to any of the above? Please explain below:

d) If you do have existing health coverage, do you intend to keep the coverage ? ☐ Yes* ☐ No

If the requested coverage is replacing an existing insurance policy, please attach a copy of the certificate and proof of payment for the past 12 months.

e) Do you or any of your dependents have active policies with BAF? ☐ Yes ☐ No If "Yes", please give the plan/product details below:

G. PAYMENT INFORMATION (The Initial Premium must be submitted with the application)

Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Premium Total* $.....

Please note that the Re-application Fee is non-refundable and exclusive of the Premium Total

Premium Payment Methods:	☐ Debit/Credit Card	☐ Online Banking	☐ Cash Payments at BAF Office

H. ACKNOWLEDGEMENT, AUTHORIZATION, AND SIGNATURE

I certify that I have read and reviewed all the answers and statements declared in this application, and that to the best of my ability, they are complete and truthful. I understand that any omissions, incorrect or incomplete statements could cause claims to be denied, and the policy to be modified, cancelled or rescinded. If any person requires medical care or treatment after the application for insurance is signed, but before the effective date of this policy, I will then provide full details to **BAF Insurance Company (Cayman) Limited**. I agree to accept the policy with the terms and conditions as issued. Otherwise, I will notify my disagreement to **BAF Insurance Company (Cayman) Limited** in writing, within the first ten (10) days of receipt of the insurance policy. In the event that I am represented by a salesperson, I hereby authorize that person to receive my policy conditions, certificate of coverage, and all documents related to my coverage.

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/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 or my dependents 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, substance abuse, 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 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.

PREFERRED METHOD OF CORRESPONDENCE: Please indicate your preferred method of receiving correspondence from BAF Cayman. ☐ Email ☐ Post

Signature of Applicant		Date (mm/dd/yy)	
Signature of Spouse*		Date (mm/dd/yy)	
Signature of Dependent(s) over 18		Date (mm/dd/yy)	
Signature of Group Admin./Salesperson		Date (mm/dd/yy)	

***Only required if listed on application**

BAF Insurance Company(Cayman) Limited
342 Dorcy Drive, P. O. Box 10389
Georgetown, Grand Cayman KY1-1004
Telephone: (345) 949-5089
www.bafcayman.com
CaymanCustomerService@mybafsolutions.com

HEALTH HISTORY **QUESTIONNAIRE**

A COPY OF THIS QUESTIONNAIRE MUST BE COMPLETED FOR EACH PERSON LISTED ON THE APPLICATION

Full Name		Date of Birth	

A. MEDICAL INFORMATION – ***Provide details for any questions answered "Yes", indicate the number and letter in the space provided***

1)	**Has the person named above ever experienced symptoms of, ever had, been treated or presently treated for:**	Yes	No
a.	Mental, Behavioral or Emotional Disorders, Alcoholism or Alcohol Abuse, Drug use or Addiction?	☐	☐
b.	Hair, Skin, Nails, Vision, Cataracts, Glaucoma, Eye Disease, Ear or Hearing, Nose or Nasal, Sinus or Throat Disorders?	☐	☐
c.	Alzheimer's, Dementia, Stroke, Multiple Sclerosis, Seizures, Migraines, Paralysis or other Neurological Disorders?	☐	☐
d.	Heart Disorders, Circulatory Disorders, High Blood Pressure, High Cholesterol or High Triglycerides?	☐	☐
e.	Allergies, Asthma, Bronchitis, Chest Pains, Long-Term effects of COVID-19 or any other Pulmonary/Respiratory Disorders?	☐	☐
f.	Esophagus, Stomach, Intestines or Pancreas Diseases, Hepatitis, Cirrhosis, other Liver Diseases or other Digestive Disorders?	☐	☐
g.	Hematuria, Proteinuria, Kidney Stones, Kidney Disorders, Urinary Tract Diseases or any Infections?	☐	☐
h.	Spinal Column and/or Cord Problems, Rheumatism, Arthritis, Gout, Hernia or any other Muscle, Joint or Bone Disorders?	☐	☐
i.	Anemia, Leukemia/Lymphoma, Malignant Lesions, Abnormal Growths, Cancer, Benign Tumor or any other Blood Disorder?	☐	☐
j.	Autoimmune, Congenital or Heredity Disorders, Paralysis, Amputation, Disability or Deformities?	☐	☐
k.	Diabetes, Goitre, Thyroid Gland Disorders, Hormone Therapy or other Endocrine/Hormonal Disorders?	☐	☐
l.	Prostate Disorders, HIV/AIDS, Sexually Transmitted Diseases, Sexual Organ Diseases or other Reproductive Disorders?	☐	☐
m.	Breasts, Ovaries, Fibroids, Endometriosis, Painful & Excessive Bleeding or Menstruation, Cysts or other Gynecological Disorders?	☐	☐
n.	Unexplained weight loss, fatigue or diarrhoea or Currently taking any Prescribed Medication or under Medical Treatment?	☐	☐
o.	Any other disease, disorder, condition, illness, injury, accident, or surgery not mentioned above?	☐	☐
p.	Any recommended or pending surgery, test and/or treatment not mentioned above?	☐	☐
q.	Have you had any abnormal test results or have been advised to repeat a test(s)? If yes, explain below.	☐	☐
r.	Have you ever or are you currently pregnant, had pregnancy complications, sterilization, under in-vitro fertilization (IVF), or any form of infertility/fertility treatment? **Females Only:** Confirm Last Menstrual Period. _____ (mm/dd/yy)	☐	☐

2)	**Been hospitalized or undergone medical studies? If "Yes", provide date, facility, reason for confinement or study and results.**	☐	☐

3)	**Received medical treatment overseas? If "Yes", provide date, name of facility, reason and type of treatment and results.**	☐	☐

4)	**Name of your Personal/Family Physician. Please provide the Address/Name of Facility, Date, Reason for Visit, Results or any prescribed treatment(s). If there is none, please state the name of the last Physician seen.**

5)	**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 ☐ Normal Delivery ☐ C-Section	
Number of days in hospital after birth: ☐	Weight at birth (lbs.):	Current weight (lbs.):	

***If the person named above is 18 months or under, please complete the Newborn & Infant Questionnaire in addition to this section.**

6) Do you have a family history of diabetes, hypertension, cancer, cardiovascular disorders, gastrointestinal disorders, neurological disorders, congenital illnesses or hereditary disorders? If "Yes", please explain below.	**Yes** ☐ **No** ☐

Relative with the disorder (please select)	Please provide name(s) of the disease/disorder. If cancer, specify type.	Age of Onset
Father ☐		
Mother ☐		
Siblings (List all) ☐		
Other (List all) ☐		

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Signature of Applicant, Spouse or Dependent if over the age of 18		**Date** (mm/dd/yy)	

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