HEALTH INSURANCE APPLICATION

Group ☐ Individual ☐

Agent/Broker		Policy Number		Effective Date	

A. APPLICANT'S INFORMATION

First Name		M.I.		Last Name	
Address	Street			P.O. Box	
City				Postal Code	
Telephone #s	Home			Mobile	
Email Address				Nationality	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widowed			National ID #	

B. PRODUCT AND PLAN SELECTION

Please select:	Prestige ☐	VPEN 250 ☐	MedSafe ☐	NW 100 ☐
Please select: (select all that apply)	New Application ☐	Plan Change ☐	Addition of Dependent(s) ☐	Reinstatement ☐
	Re-application ☐			

C. IMMIGRATION STATUS (Please state "Yes" where applicable and provide details if necessary)

Insured	Caymanian		Permanent Resident	
	Work Permit Holder		Other	
Spouse	Caymanian		Permanent Resident	
	Work Permit Holder		Other	

D. APPLICANT & DEPENDENT INFORMATION

	Family Members' Names (List all family members) Last / First / Middle	Birth Date (DD/MM/YYYY)	Place of Birth & Nationality	Sex M F	Smoker Yes No	Height Ft. Ins.	Weight Lbs.
Applicant				☐ ☐	☐ ☐		
Spouse				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		

If this application includes children **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 or university and provide proof (e.g. letter, document showing 12 or more credits) from the college or university as evidence of full-time student status.

E. EMPLOYMENT INFORMATION

Employer's Name		Authorized Signature	
Full Address		Title/Occupation	
E-mail Address		Date of Employment	
Telephone Number		Hours Worked/Salary	

Other Medical Benefits and Previous Health Insurance History: Are Medical Benefits available for you, your spouse or any of your dependents from any mother source? (e.g. Company, Insurer, Employer, 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 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) Do you intend to keep your existing health insurance coverage? ☐ Yes ☐ No

e) Do you or any of your dependents have active policies with BAF? ☐ Yes ☐ No **If yes, please provide plan details below.**

G. PAYMENT INFORMATION

Mode: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Payment Methods:	**Premium Total $..........................**		
☐ Online Banking	☐ Debit/Credit Card	☐ Post-dated Cheques	☐ 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** for final approval before coverage is effective. 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 an agent or broker, 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 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 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.

Signature of Applicant		Date	
Signature of Spouse		Date	
Signature of Dependent Child over 18		Date	
Signature of Agent/Group Administrator		Date	

BAF Insurance Company (Cayman) Limited
342 Dorcy Drive, P.O. Box 10389
Georgetown, Grand Cayman KY1-1004 Tel:
(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

Name		Date of Birth	

A. MEDICAL INFORMATION - ***Provide details for any questions answered "Yes", indicating the number and letter on the Additional Information sheet provided.***

		Yes	No
1	Has the person named above ever experienced symptoms of, ever had, been treated or presently treated for:		
a.	Acquired Immune Deficiency Syndrome (AIDS), Human Papillomavirus (HPV), Kaposi's Sarcoma, Heart Disorder, Eye Conditions/ Disorders, Cancer, Tumor or any other abnormal growth, Alcoholism or Alcohol Abuse, Drug Use or Addiction?	☐	☐
b.	Disease or Disorder of the Urinary Tract, Digestive System, Reproductive System, Liver, Back, Bones or Joints?	☐	☐
c.	Diabetes/Elevated Glucose or Sugar, High Blood Pressure, Asthma, Chronic Pneumonia, Chest Pain, Seizure Disorder or Epilepsy, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis, Blood disorder or Anemia, elevated cholesterol?	☐	☐
d.	Thyroid disorder, Paralysis, Arthritis, Multiple Sclerosis, Dementia, Alzheimer's, Nervous or Mental Disorder?	☐	☐
e	Any other disease, disorder, symptom or deformity not mentioned above?	☐	☐
2	Has the person named above had medical expenses exceeding $1,000 over the past three (3) years?	☐	☐
3	Is the person named above:		
a.	Currently taking any prescribed medication or under medical treatment?	☐	☐
b.	Currently pregnant? If yes, please state **(i)** LMP ___________ (mm/dd/yy) and/or **(ii)** Number of weeks/months ____________	☐	☐
c.	Totally or partially disabled?	☐	☐
4	Within the last three years, has the person named above:		
a.	Consulted any doctor? If "Yes", please provide date, name of physician, reason for visit, treatment and results.	☐	☐
b.	Been hospitalized or undergone medical studies? If "Yes", provide date, facility, reason for confinement or study and results.	☐	☐
c.	Received Medical treatment overseas? If "Yes", provide date, name of facility, reason and type of treatment and results.	☐	☐
5	Name of your Personal/Family Physician. If there is none, please state the name of the last Physician seen.		

Name	
Address	Telephone Number:

6 Have you ever been advised to have any diagnostic test, treatment or surgery which has not been completed? Yes ☐ No ☐
Have you had any abnormal test results or have been advised to repeat a test(s)? Yes No If yes, please explain below.

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:	Current weight:

7 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. If cancer, specify type.	Age of Onset
Father ☐		
Mother ☐		
Siblings (List all) ☐		
Other (List all) ☐		

B. ACKNOWLEDGEMENT, AUTHORIZATION & SIGNATURE

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Signature of Applicant – OR Dependent if over the age of 18		**Date**	

ADDITIONAL INFORMATION

Please indicate the section and question you are providing additional information for:

AUTHORIZATION & SIGNATURE

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Signature of Applicant/Dependent		Date	

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COVID-19 AMENDMENT DOCUMENT

NAME OF PROPOSED INSURED:		**D.O.B.**	

This document shall form part of the application for a health policy/account made by the undersigned, and it is agreed that the application shall be deemed to be amended to accord with the following:

1) **Have you ever had any COVID-19 related symptoms (eg. a persistent cough, fever, raised temperature, loss of taste or smell) or been in contact with an individual suspected or confirmed to have COVID-19?** *If yes, give details*________________________________ □ **YES** □ **NO**

2) **Have you ever required medical advice or had to self-isolate due to COVID-19 - excluding mandatory government orders to remain at home?** *(If yes, give details below)* □ **YES** □ **NO**

i. Physician/Facility ______________ **ii. Advice given:** ______________

iii. Period of self-isolation: **From:** ______________ **To:** ______________

iv. Symptoms: ______________

v. Treatment: ______________

vi. Are you now fully recovered: □ **YES** □ **NO** **If no, give details:** ______________

vii. Date returned to work/normal activities: ______________

3) **Have you ever tested positive for COVID-19?** *(If yes, give details below)* □ **YES** □ **NO**

i. Date: ______________ **ii. Date cleared of COVID-19:** ______________

iii. Symptoms: ______________

iv. Were you hospitalized? *(if yes, state physician and location)*: ______________

v. Treatment: ______________

vi. List all medication currently taken: ______________

vii. Are you now fully recovered: □ **YES** □ **NO** **If no, give details:** ______________

viii. Do you have any other conditions/complications?: ______________

ix. Date returned to work/normal activities: ______________

The statements contained in the application as so amended are true and complete and there has been no change in the health, habits, occupation, activities and family history of the life or lives to be insured since the making of the application. The statement above and the signature recorded below are identical on the copy of the "COVID-19 Amendment Document" attached to this policy/account and the copy for head office.

Signed at________________________this________day of__________________________20 _______

Proposed Insured's Signature

Agent/Group Administrator's Signature

July 2021