APPLICATION FOR GROUP INSURANCE

Requested Effective Date: ____________________

Legal name of firm: ____________________

Full Address: ____________________

____

Years of operation: ____________________

Contact person: ____________________ Telephone No. __________ Email: ____________________

Owner: ____________________ Telephone No. __________ Email: ____________________

Type of ownership: ☐ Proprietorship ☐ Partnership ☐ Corporation Fax No. ____________________

Nature of business/articles sold, manufactured or services rendered: ____________________

____

Are employees of any subsidiary or secondary locations of your firm to be included in the plan? ☐ Yes ☐ No

If YES, supply the name of each firm, address, relationship among firms and number of employees at each location on a separate sheet.

EMPLOYEE/PLAN INFORMATION

1. How many hours per week must your employees work to be considered eligible for insurance benefits?
   ☐ 30 or more hours per week ☐ __________hours per week
2. Employees to be covered: ☐ Active employees only ☐ Active and retired employees (attach a list of all eligible retirees)
3. How many eligible employees do you have including yourself? ____________________
4. Are any employees to be excluded from the plan? ☐ Yes ☐ No If YES, how many? ____________________
   Please explain ____________________
5. Are any employees related? __________ If YES, how many? __________
6. Employer contributions: Employees $__________/ __________% Dependents $__________/ __________%
7. Is this insurance intended to replace any of the following existing group coverage?

	Medical coverage	Dental coverage
If YES:	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Insurance Company	__________	__________
Policy # or Group #	__________	__________
Effective date of plan:	__________	__________
Termination date of plan	__________	__________

Include a copy of the current carrier's booklet and most current premium statement listing those currently insured.

DO NOT TERMINATE ANY EXISTING COVERAGE UNTIL THIS REQUEST IS APPROVED BY BAF INSURANCE COMPANY.

8. If you are **NOT** requesting Major Medical benefits, do you have other group medical coverage? ☐ Yes ☐ No

If YES, with whom? Name: ____________________

Address: ____________________

9. Are any employees currently absent due to illness or injury, or receiving disability benefits? ☐ Yes ☐ No

If YES, give names and details of disability conditions: ____________________

____

Continued overleaf

ELECTED BENEFITS AND OPTIONS

SELECT OPTIONS DESIRED. (Only options specifically selected will be included)

1. Life and AD & D Benefits for active employees ☐ Yes ☐ No

Class Description ____________________ Amount ________

____________________ ________

____________________ ________

Amounts in excess of $50,000 require full Evidence of Insurability Form completion and approval. Multiple of employee's annual salary not to exceed 2.5 times.

2. Life Benefits for retired employees ☐ Yes ☐ No

Class Description ____________________ Amount ________

____________________ ________

3. Dependent Life Insurance ☐ Yes ☐ No

Spouse amount $ ________

Child 15 days to 6 months amount $ ________

Child 6 months to 19 years amount $ ________

4. Major Medical Benefits ☐ Yes ☐ No

Calendar year deductible $ ________ single $ ________ family

Coinsurance percentage ________ %

Out-of-pocket maximum $ ________ (excludes deductible)

5. Dental Benefits ☐ Yes ☐ No

Calendar year deductible $ ________ single $ ________ family

Coinsurance percentage ________ % Diagnostic/Preventative

________ % Basic/Restorative

________ % Major/Replacement

________ %Orthodontic

Yearly maximum $ ________

5. Vision Benefits ☐ Yes ☐ No

Eye Examination $ ________ Lenticular lens $ ________

Single vision lenses $ ________ Frames $ ________

Bifocal Lenses $ ________ Contact Lens $ ________

Trifocal Lenses $ ________ Contacts (Medical) $ ________

AGREEMENT: We hereby request that we be approved for coverage under and hereby accept and agree to be bound by the terms and Group Policy. We request that the group insurance benefits we elected on this form be made available to all of our eligible employees in accordance with the terms of the group insurance policy. We agree to contribute a minimum of 25% of the employee's cost. We also agree to remit in advance the required employer payments. Enclosed is (1) our cheque for the initial required amount, (2) the necessary enrollment forms and waiver forms, and (3) any initially required Evidence of Insurability. (Make all cheques payable to BAF Insurance Company (Cayman) Ltd.) **WE UNDERSTAND** that insurance begins as of the effective date approved by BAF Insurance Company (Cayman) Ltd. We also understand that the agent does not have the authority to approve effective dates or to change or modify coverage or conditions of the plans. **WE UNDERSTAND** that the plans contain pre-existing conditions limitations. **COMPLIANCE WITH EMPLOYMENT LAWS: WE UNDERSTAND** that, as an employer we may be subject to laws, as we further understand and agree that we are solely responsible for compliance with such laws, including the payment of any required benefits which are not covered by this insurance plan. Any person who, has intended to defraud of knowing that he is facilitating a fraud against an insurer submits an application of files a claim containing a false or deceptive statement may be guilt of insurance fraud.

DO NOT TERMINATE ANY EXISTING COVERAGE UNTIL THIS REQUEST IS APPROVED BY BAF INSURANCE COMPANY.

Dated: ________ Full legal name of company: ________

At: ________ By: (signature & title) ________

Writing agent: ________