

# B.F. 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					Island		
Telephone #s	Home				Mobile		
Email Address					Nationality		
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	National ID #		

## B. PRODUCT AND PLAN SELECTION

Please select:	Prestige <input type="checkbox"/>	VPEN 250 <input type="checkbox"/>	MedSafe <input type="checkbox"/>	NW 100 <input type="checkbox"/>
	New Application <input type="checkbox"/>	Plan Change <input type="checkbox"/>	Addition of Dependent(s) <input type="checkbox"/>	Reinstatement <input type="checkbox"/>

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

Main Insured	Caymanian /Status Holder		Permanent Resident	
	Work Permit Holder		Other	
Spouse	Caymanian/Status Holder		Permanent Resident	
	Work Permit Holder		Other	

## D. APPLICANT & DEPENDENT INFORMATION

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

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 (payment must be submitted with the application)**

Mode:  Monthly  Quarterly  Semi-Annually  Annually

<b>Payment Methods:</b>	<b>Premium Total \$.....</b>		
<input type="checkbox"/> Online Banking	<input type="checkbox"/> Debit/Credit Card	<input type="checkbox"/> Post-dated Cheques	<input type="checkbox"/> 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		Date	



# HEALTH HISTORY QUESTIONNAIRE

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

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

1	Has the person named above ever experienced symptoms of, ever had, been treated or presently treated for:	Yes	No
a.	Acquired Immune Deficiency Syndrome (AIDS), Chronic Pneumonia, Kaposi's Sarcoma, Heart Disorder, Eye Conditions/ Disorders, Cancer, Tumor or any other abnormal growth, Alcoholism or Alcohol Abuse, Drug use or Drug Addiction?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Disease or Disorder of the Urinary Tract, Digestive System, Reproductive System, Liver, Back, Bones or Joints?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Diabetes/Elevated Glucose or Sugar, High Blood Pressure, Asthma, Chest Pain, Seizure disorder or Epilepsy, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis, Blood disorder or Anemia, elevated cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Thyroid disorder, Paralysis, Arthritis, Multiple Sclerosis, Dementia, Alzheimer's, Nervous or Mental Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Any other disease, disorder, symptom or deformity not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>
2	Has the person named above had medical expenses exceeding \$1,000 over the past three (3) years?	<input type="checkbox"/>	<input type="checkbox"/>
3	Is the person named above:		
a.	Currently taking any prescribed medication or under medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Currently pregnant? If yes, please state the gestation period, number of weeks and/or months.	<input type="checkbox"/>	<input type="checkbox"/>
c.	Totally or partially disabled?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
b.	Been hospitalized or undergone medical studies? If "Yes", provide date, facility, reason for confinement or study and results.	<input type="checkbox"/>	<input type="checkbox"/>
c.	Received Medical treatment overseas? If "Yes", provide date, name of facility, reason and type of treatment and results.	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>
	Have you had any abnormal test results or have been advised to repeat a test(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain below.

<b>If the person named above is less than 5 years old, please provide the following information:</b>		
Was the child delivered at full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were there any complications at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of childbirth <input type="checkbox"/> Normal Delivery <input type="checkbox"/> 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 <input type="checkbox"/>		
Mother <input type="checkbox"/>		
Siblings (List all) <input type="checkbox"/>		
Other (List all) <input type="checkbox"/>		

**B. ACKNOWLEDGEMENT, AUTHORIZATION & 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.

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**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.

<b>Signature of Applicant – OR Dependent if over the age of 18</b>		<b>Date</b>	
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# COVID-19 AMENDMENT DOCUMENT

<b>NAME OF PROPOSED INSURED:</b>	<b>D.O.B.:</b>
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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

<b>i. Physician/Facility</b>	<b>ii. Advice given:</b>
<b>iii. Period of self-isolation:</b>	<b>From:</b> _____ <b>To:</b> _____
<b>iv. Symptoms:</b> _____	
<b>v. Treatment:</b> _____	
<b>vi. Are you now fully recovered:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If no, give details:</b> _____
<b>vii. Date returned to work/normal activities:</b> _____	

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

<b>i. Date:</b>	<b>ii. Date cleared of COVID-19:</b>
<b>iii. Symptoms:</b> _____	
<b>iv. Were you hospitalized?</b> <i>(if yes, state physician and location):</i> _____	
<b>v. Treatment:</b> _____	
<b>vi. List all medication currently taken:</b> _____	
<b>vii. Are you now fully recovered:</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO <b>If no, give details:</b> _____
<b>viii. Do you have any other conditions/complications?:</b> _____	
<b>ix. Date returned to work/normal activities:</b> _____	

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