



# 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	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/Widower				
Nationality					

	Applicant	Spouse
Occupation		
Employer's Name		
Nature of Business		

	Family Members Names <small>(only if dependent is being enrolled)</small>			Birth Date <small>(DD/MM/YYYY)</small>	Birthplace	Sex		Smoker		Height <small>Ft : Ins</small>	Weight <small>in lbs</small>
	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"/>	
Child							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**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	
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# HEALTH HISTORY QUESTIONNAIRE

One form should be completed for each person to be insured.

Name		Date of Birth	
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Please list your previous health insurance provider

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?	<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, High Blood Pressure, Asthma, Chest Pain, Seizure disorder, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis or Blood disorder, elevated cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
d	Tumor or any other abnormal growth, Thyroid disorder, Paralysis, Arthritis, Nervous or Mental Disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e	Any other Physical disorder or deformity?	<input type="checkbox"/>	<input type="checkbox"/>
f	Eye Disease?	<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	Has the person named above ever had or applied for Health Insurance? If "Yes", please advise	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
b	Currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
c	Totally or partially disabled?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
b	Been hospitalized or undergone medical studies? If, Yes , please specify the Diagnosis, date and results below.	<input type="checkbox"/>	<input type="checkbox"/>
c	Received Medical treatment overseas? If Yes , please specify the name of the Provider or Facility, date of Diagnosis and results below.	<input type="checkbox"/>	<input type="checkbox"/>

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? <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"/> C-section <input type="checkbox"/> Vaginal delivery
Number of days in hospital after birth**:	Weight at birth:	Current weight:

## APPLICANT'S AUTHORIZATION

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 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
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