GROUP ENROLLMENT FORM

BROKER/AGENT:		EFFECTIVE DATE:	

Group Number: Employer:	P.O. Box:	Phone Number:	Town:
Employee Name: Last First M.I.		**Sex:** ☐ M ☐ F	Salary:
		Marital Status: ☐ S ☐ M ☐ D ☐ W	Hours worked per week:
Employer Address:		Date Employed:	Position:
Beneficiary Name:	Relationship:	Address:	
Is your Spouse Employed? ☐ Yes ☐ No			

PROSPECTIVE ENROLLEE INFORMATION Last First M.I.	Birth Date (D/M/Y)	Birthplace	Sex	Smoker?	Height Ft : ins	Weight In lbs
Applicant			☐ M ☐ F	☐ Yes ☐ No		

DEPENDENT/FAMILY MEMBERS' NAMES *List only if dependent is being enrolled.* Last First M.I.		Birth Date (M/D/Y)	Birthplace	Sex	Smoker?	Height Ft : ins	Weight In lbs
Spouse				☐ M ☐ F	☐ Yes ☐ No		
Child				☐ M ☐ F	☐ Yes ☐ No		
Child				☐ M ☐ F	☐ Yes ☐ No		
Child				☐ M ☐ F	☐ Yes ☐ No		
Child				☐ M ☐ F	☐ Yes ☐ No		

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 indicate source s name and telephone number:	
In respect of you, your spouse or any of our 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 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's Underwriting Standards and that they are not already covered under another medical insurance plan, such as a group plan.

Signature of Applicant		Date	

HEALTH HISTORY QUESTIONNAIRE

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

Name		Date of Birth	

Please list your previous health insurance provider

		Yes	No
1	Has the person named above ever had or been treated for:		
a	Acquired Immune Deficiency Syndrome (AIDS), Chronic Pneumonia, Kaposi s Sarcoma, Heart Disorder, Cancer, Alcoholism or Alcohol Abuse, Drug use or Drug Addiction?	☐	☐
b	Disease or disorder of the Urinary Tract, Digestive System, Reproductive System, Liver, Back, Bones or Joints?	☐	☐
c	Diabetes, High Blood Pressure, Asthma, Chest Pain, Seizure disorder, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis or Blood disorder, elevated cholesterol?	☐	☐
d	Tumor or any other abnormal growth, Thyroid disorder, Paralysis, Arthritis, Nervous or Mental Disorder?	☐	☐
e	Any other Physical disorder or deformity?	☐	☐
2	Has the person named above had medical expenses exceeding $1,000 over the past three (3) years?	☐	☐
3	Has the person named above ever had or applied for Health Insurance? If "Yes", please advise	☐	☐
4	Is the person named above:		
a	Currently taking any prescribed medication or under medical treatment?	☐	☐
b	Currently pregnant?	☐	☐
c	Totally or partially disabled?	☐	☐
5	Within the last three years, has the person named above:		
a	Consulted any doctor? If Yes , please specify:	☐	☐
b	Been hospitalized or undergone medical studies? If, Yes , please specify:	☐	☐
c	Received Medical treatment overseas? If Yes , please specify:	☐	☐

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? ☐ Yes ☐ No	Were there any complications at birth? ☐ Yes ☐ No	Method of childbirth ☐ C-section ☐ Vaginal delivery
Number of days in hospital after birth**:	Weight at birth:	Current weight:

Applicant's Authorization

I UNDERSTAND THAT HEALTH INSURANCE BEENFTS 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**	