



APPLICATION FOR SHIC HEALTH INSURANCE
 PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED
 (Note: The information on this form is treated as confidential)

Check One:				Agent Name:	
<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Self Employed	<input type="checkbox"/> Retired	Policy #:	Effective Date <small>(MM/DD/YY)</small>

SECTION A – APPLICANT INFORMATION

Last Name		Date of Birth <small>(MM/DD/YY)</small>	Height ft in	Weight lbs	IMMIGRATION STATUS <input type="checkbox"/> Caymanian/Status Holder <input type="checkbox"/> Work Permit Holder <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other _____
Middle Name					
First Name					
Postal Address			Current Residential Address		
Email Address			Sex: (M/F)	Cellular	Work Tel
Beneficiary Name	Date of Birth <small>(MM/DD/YY)</small>	Relationship	Postal Address	Telephone	

SECTION B – EMPLOYER INFORMATION

Name	Signature		
Email Address	Office Telephone		
Physical Address	Postal Address		
Current Insurance Carrier	Policy ID	Effective Date <small>(MM/DD/YY)</small>	Est. Termination Date <small>(MM/DD/YY)</small>

SECTION C – ELIGIBLE DEPENDENTS

PLEASE PROVIDE THE REQUIRED INFORMATION ON DEPENDENTS TO BE COVERED (Dependents must reside in the Cayman Islands)
 (If necessary, please provide additional information on a separate page and attach it to this form.)

Name	Date of Birth <small>(MM/DD/YY)</small>	Sex <small>(M/F)</small>	Relationship	Height ft in	Weight lbs	Current Employer <small>(if applicable)</small>	Employer's Current Health Insurance Carrier	Effective Date of Insurance <small>(MM/DD/YY)</small>	Immigration Status

I. Are medical benefits available from any other approved insurer to any person listed above (Section A &/or Section C)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: > > >	Dependent Name	Approved Insurer	Effective Date <small>(MM/DD/YY)</small>	Telephone

II. Has any person listed above (Section A &/or Section C) had continuous coverage for a period of less than one year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information: > > >	Dependent Name	Approved Insurer	Effective Date <small>(MM/DD/YY)</small>	Telephone



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SECTION D – MEDICAL QUESTIONNAIRE (MUST BE COMPLETED BY ALL PERSONS)

(If necessary, please provide additional information on a separate page and attach it to this form)

In the last twelve months has any persons listed above (Section A &/or Section C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Heart or circulatory system (including but not limited to infraction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmia, disease of veins, arteries, or valves, stroke) and/or any other symptoms regarding circulatory system or heart.	□Yes □No
2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (Aids Related Complex).	□Yes □No
3. Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infraction (stroke), Alzheimer’s disease, dementia) and /or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.	□Yes □No
4. Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which is referred to a doctor would result in a diagnosis.	□Yes □No
5. Kidney/Renal disease or failure.	□Yes □No

In the last twelve months has any person listed above (Part A & or Part C) ever:

6. Been treated for cancer? If yes, please explain:	□Yes □No
7. Been treated for Diabetes (sugar), Hypertension (high blood pressure)? If yes, please explain	□Yes □No
8. Been treated for Respiratory conditions? If yes, please explain:	□Yes □No
9. Had an organ transplant? If yes please explain:	□Yes □No
10. Had major surgery? If yes, please explain:	□Yes □No
11. Are you currently on medications? If yes, please specify.	□Yes □No
12. Females only: Are you pregnant? If yes please specify the number of weeks gestation	□Yes □No

Has any approved insurer within the last twelve months:

13. Declined an application for health insurance?	□Yes □No
14. Required an increased premium or imposed special condition?	□Yes □No
15. Cancelled or refused to renew an existing health insurance policy?	□Yes □No

DECLARATION AND AUTHORIZATION

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.
 I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to BAF Insurance (Cayman) Limited. A photocopy of this signed authorization shall be valid as the original.
 I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of the coverage.
 I understand and agree that coverage shall not become effective until accepted by BAF Insurance (Cayman) Limited.
 I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to BAF Insurance (Cayman) Limited.

Applicant’s Signature _____

Date (MM/DD/YY) _____

Spouse’s Signature _____

Date (MM/DD/YY) _____

**THIS APPLICATION WILL BE VALID FOR THIRTY (30) DAYS FROM THE DATE OF SIGNATURE.
 FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID**

FOR BAF INSURANCE USE ONLY:

Comments