CG | INSURANCE

GROUP INSURANCE APPLICATION

Premier Health

This Application relates to: ☐ New Business ☐ Amendment to Existing Business*: Policy No._____

*If requesting an Amendment to an existing Group Contract, please complete only those areas in which the information is changing. Please complete this application with as much detail as possible and send it back to your Agent/Broker/Sales Representative.

PART 1 EMPLOYER DETAILS

Company Name _____

Mailing Address _____

Street Address _____

Contact Person - Billing _____ E-mail _____

☐ Monthly statement to be emailed. **Note:** Statements can be sent to up to 3 contacts. If desired, please advise 2 more recipients:

Email2 _____ Email3 _____

Contact Person - Admin. _____ E-mail _____

Phone No. _____ Fax No. _____

Agent _____ Broker _____

Type of Business _____ Effective Date (DD/MM/YY) _____

Organisation Type ☐ Partnership ☐ Trust ☐ Foundation ☐ Charity ☐ Private Company ☐ Public Company
☐ Other Fund (specify): _____ ☐ Other (specify) _____

Organisation Operations ☐ Local ☐ International ☐ Listed on stock exchange (which exchange?) _____

Description and Nature of the Business/Trust/Partnership etc. _____

_____

Organisation Website: _____

What other Coralisle Group Products do you have? ☐ Motor Insurance ☐ Home Insurance: ☐ Building ☐ Contents
☐ Travel Insurance ☐ Business Insurance ☐ Life Insurance: ☐ Group ☐ Individual
☐ Pension ☐ Medical Insurance ☐ Other _____

Total number of employees _____ Total number of dependents _____ Total number aged 65 years and over _____

PART 2 TYPE OF COVER REQUESTED

☐ **Medical Plan Benefit** LTM: ☐ $1M ☐ $2M Deductible/OOP Max. Option: ☐ $200/$1,000 ☐ $500/$5,000 ☐ $1,000/$10,000

☐ **Dental Plan Benefit** Effective Date (DD/MM/YY): _____ ☐ Basic ☐ Comprehensive

☐ **Vision Plan Benefit** Effective Date (DD/MM/YY): _____

☐ **Group Life Benefit** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ Flat Amount $ _____ OR ☐ Multiple of *Salary _____ Max. Benefit _____

☐ **Supplemental Life Benefit**** _____

☐ **Dependent Life Benefit** ☐ Flat Amount for Spouse $ _____ ☐ Flat Amount for Child $_____

☐ **Accidental Death And Dismemberment Benefit (AD&D)** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ Flat Amount $ _____ OR ☐ Multiple of *Salary _____ Max. Benefit _____

☐ **Short-Term Disability Benefit** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ _____ % of *Salary ☐ Flat Amount - $ _____ ☐ Sickness - _____Days

☐ Accident - _____ Days ☐ Maximum Amount - $_____ ☐ Maximum Period - _____

☐ **Long-Term Disability Benefit** For Long-Term Disability, a separate application form is required.

☐ **Critical Illness Benefit**** Max. Benefit ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ **Supplemental Accident Benefit****

** These Optional benefits will be: ☐ Voluntary (Employee funded) OR ☐ Non-Voluntary (Company funded)

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PART 3 KYC REQUIREMENTS

1. Purpose of the account, source of funds and the estimated account activity:_____

_____

_____

2. The term "Politically Exposed Person" applies to persons who have or have had positions of public trust such as government officials, senior executives of government corporations, politicians, important political party officials etc. and their families and close associates. Does this description apply to any of the Entity's beneficial owners, directors, settlors and/or signatories? ☐ Yes ☐ No

   If Yes, please explain: _____

   _____

3. Please list of all Beneficial Owners of the Organisation with 10% or more ownership:

Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____
Name _____ Email _____ Ownership % _____

Note: Please include a certified copy of Register of Shareholder.

4. Please list all Directors/Trustees or equivalent:

Name _____ Email _____ Title _____
Name _____ Email _____ Title _____
Name _____ Email _____ Title _____
Name _____ Email _____ Title _____
Name _____ Email _____ Title _____
Name _____ Email _____ Title _____
Name _____ Email _____ Title _____

Note: If the Organisation is a Trust, please provide the name of the Protector/Controller:

5. Please list all Authorized Signatories (individuals authorized to issue instructions on the Organisation's behalf):

Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____
Name _____ Email _____ Signature _____ Date _____

6. Please confirm how we should accept instructions/requests from the Organisation: ☐ Any 1 signatory ☐ Any 2 signatories
   ☐ Other method of authorization (please specify) _____

Premier Health

7. Please supply the following documentation. These basic requirements are mandatory for **all** clients:

- ☐ The Entity's certificate of incorporation, trade and business license, charter, constitution or other appropriate documentation attesting to the existence of the Entity, such as a social insurance statement or payroll tax registration in the Entity's name
- ☐ Letter of Authority (printed on Client's letter head) to enter into the business relationship with Colonial Medical Insurance Company Limited and authorized individual(s) (if appropriate) who will provide instructions on behalf of the Entity.
- ☐ Provide completed Individual Information Forms for any controlling person (i.e. Beneficial Owner, Director/Trustee, Trust Protector/Controller and any Authorized Signatory), including a certified copy of a Photo ID and Proof of Address.
- ☐ Proof of physical business address such as utility bill or bank or credit card statement (not more than 90 days old) in the Entity's name

In addition to the basic requirements, **Charities/Associations** must also attach:

- ☐ A letter indicating the Charity/Organization is registered, and the Charity Registration Number.

PART 4 DECLARATION

In connection with this application to Coralisle Medical Insurance Company Ltd. ("Coralisle Medical"), the applicant agrees and understands that:

a. Insurance on any individual shall not take effect until the effective date of the policy;

b. Insurance for which proof of insurability is required will not become effective until insurability is approved by Coralisle Medical;

c. Coralisle Medical reserves the right to restrict/revoke cover should any of the application or enrollment materials contain any misrepresentations;

d. The information contained in this application is, to the best of the applicant's knowledge, true and correct, and no material fact has been misrepresented, misstated or withheld;

e. This application shall be incorporated into and shall constitute a part of the policy contract between me/us and Coralisle Medical;

f. The Entity must advise Coralisle Medical of any future changes whatsoever that could affect the operation of the plan and subsequently, our relationship; and

g. The Agent/Broker whose name appears over is the applicant's Agent of Record.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

PART 5 CONFIDENTIALITY CLAUSE

I/We also understand that all information provided will be kept confidential and Coralisle will abide by the provisions of the applicable jurisdictional Data Privacy & Protection Rules and Regulations

Signature of Applicant: _____ Date: _____

PART 6 AGENT/BROKER INFORMATION

Agent/Broker's Name: _____

Statement of Agent/Broker: I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted. To the best of my knowledge and belief, all statements in the Application for Group Insurance are true and complete. I have read and I understand the form.

Signature of Agent/Broker_____ Date: _____

PART 7 SALES REPRSENTATIVE

Sales Representative Name:_____

Signature of Sales Representative: _____ Date: _____

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PART 8 GROUP CENSUS

Please use the separate Spreadsheet provided to submit the required details for your Group's Employees.

PART 9 NOTES, COMMENTS &/OR QUESTIONS

Coralisle Insurance Brokers (TCI) Ltd. Regent Village West, Units J102-J104, Ventura Drive, Grace Bay, Providenciales TKCA 1ZZ
Turks and Caicos Islands | Tel 649 941 3195 | Fax 649 941 3197 | www.CGCoralisle.com