CG | INSURANCE

ENROLMENT FORM

Solus Health

PART 1 PRIMARY INSURED'S DETAILS

Surname ________________ First Name ________________ Initials ________

Date of Birth (DD/MM/YY) ____________ Height ________ in. Weight ______ lbs. ☐ Male ☐ Female

Position/Job Title ________________ Country of Citizenship ____________

Address ________________________________

Home Phone ________________ Cell Phone ________________

Email (Work) ________________ (Home) ________________

PART 2 COVERAGE DETAILS

All selected Coverage is for: ☐ Myself Only ☐ Myself plus my Spouse ☐ Myself plus my Child(ren) ☐ Myself plus my Family

Selected Coverage Benefits: ☐ Major Medical - Deductible Choice: ☐ $200 ☐ $500 ☐ $1,000 ☐ Dental ☐ Vision

☐ Critical Illness ☐ Supplemental Accident* Life Plan* Benefit: ☐ $10,000 ☐ $25,000

Payment Option: ☐ Annual ☐ Semi-Annual (plus 3% Service Fee) ☐ Quarterly (plus 6% Service Fee)

Effective Date: 1st day of ________________ 20 ____

*Beneficiary(ies) Name	Date of Birth	Relationship	Mailing Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update your Beneficiary details.

If a named Beneficiary is under 18, please name a Guardian/Trustee. ________________

PART 3 MEDICAL HISTORY OF PRIMARY INSURED Please complete if requesting benefits for yourself

Have you at any time been treated for or been told that you had trouble with any of the following? Check YES or NO.

If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug/Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?	☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?	☐	☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY) ________ LMP date? ________	☐	☐
25. Do you or your dependent(s) have medical coverage with another health insurer?	☐	☐
26. Have you or your dependents ever had coverage with Coralisle Medical Insurance?	☐	☐

25. If yes, please provide the name of the health insurer: ________________ and effective date: ________

26. If yes, please provide the name of the employer ________ effective date ______ and/or term date ______

PART 4 DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) Please complete if requesting benefits for your eligible dependents

Full Name (please print)	Address (if different from Insured)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

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PART 5 MEDICAL HISTORY OF DEPENDENT(S) Please complete if requesting benefits for your eligible dependents

Have you at any time been treated for or been told that you had trouble with any of the following? Please tick YES or NO
If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug/Alcohol Dependency, Abuse, Addiction)	☐	☐

17. Have you had any drug(s) prescribed during the past three years? ☐ ☐
18. Have you been a patient in a hospital or similar institution during the past three years? ☐ ☐
19. Have you been examined by or consulted a doctor during the past three years? ☐ ☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so? ☐ ☐
21. Have you been advised to have a surgical operation or procedure but did not do so? ☐ ☐
22. Have you any known physical impairments, deformities or ill health not covered above? ☐ ☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified? ☐ ☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY)______________ LMP date?______________ ☐ ☐
25. Do you have medical coverage with another health insurer? ☐ ☐
If yes, please provide the name of the health insurer:______________________________ and effective date: ____________
26. Have you ever had coverage with Coralisle Medical Insurance? ☐ ☐
If yes, please provide the name of the employer__________________ effective date________ and/or term date ________

PART 6 MEDICAL HISTORY DETAIL - If you answered Yes to any questions in Parts 3 and/or 5, please detail here

Patient Name	Ques. No.	Diagnosis	Medications/Treatments	Recovery Date (MM/YY)	Name & Address of Physician
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

PART 7 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Premier Health individual plan from Coralisle Medical. I authorize any attending physician, surgeon, clinic, hospital, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to CORALISLE MEDICAL INSURANCE COMPANY LIMITED or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent on whom insurance is being requested. I understand that my insurance will cease only at the end of the Premium Period and that there will be no pro-rata refund of premium. **Furthermore, I understand that should I non-disclose or misrepresent any information, either intentionally or negligently, for either myself or any dependents, Coralisle Medical reserves the right to restrict or revoke cover.**

Primary Insured's Signature ____ Date ____________________

You may on occasion be contacted by a company within the Coralisle Group with offers and/or information in respect of other Coralisle Group products. We confirm that only your contact details will be available to Coralisle Group personnel for such purposes and that your private information will not otherwise be transferred between Coralisle Group companies or to any other third parties without your consent to do so. If you **DO NOT** wish to be contacted in this manner by Coralisle Group personnel, please check here ☐. Note that unless you check this box, Coralisle will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.

Internal Use Only	BMI ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other
Initial & Date							

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

Personal and Business Insurance, Health Insurance and Employee Benefits

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