CG | INSURANCE

REQUEST FOR PROPOSAL

Premier Health

The information requested on this form (including the accompanying spreadsheet) is designed to assist in accurately evaluating your Group. It is essential that the information provided be complete and true to the best of your knowledge.

PART 1 APPLICANT DETAILS

Company Name _____

Mailing Address _____

Street Address _____

Contact Person _____ E.Mail _____

Phone No. _____ Fax No. _____

Total Number of Employees _____ Total Number of Dependents _____

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

Previous Medical Client? ☐Yes ☐No If Yes, previous Policy No._____ Cancellation Date (DD/MM/YY)_____

PART 2 TYPE OF COVER REQUESTED ☐ New Business ☐ Change Existing Business: Policy _____

PART 3 TYPE AND DETAILS OF COVER REQUESTED (indicate benefits along with any specific requirements)

Medical Benefits

☐ **Medical Plan Benefit** ☐ Premier Health ☐ Provident Plan ☐ HIP Enhanced ☐ HIP

☐ **Dental Plan Benefit** ☐ Comprehensive ☐ Basic

☐ **Vision Plan Benefit**

☐ **Group Life Insurance Benefit** ☐ Flat Amount of $_____ or ☐ Multiple of Salary = ☐x1 ☐x2 ☐x3 ☐x4

☐ **Accidental Death & Dismemberment Benefit** ☐ Flat Amount $_____ or ☐ Multiple of Salary = ☐x1 ☐x2 ☐x3 ☐x4

☐ **Short-Term Disability Benefit** ☐ 50% ☐ 60% ☐ 66.66% of Weekly Salary to a Max Amount of $_____

☐ **Long-Term Disability Benefit** ☐ 50% ☐ 60% ☐ 66.66% ☐ 70% of Monthly Salary to a Max Amount of $ _____
Waiting Period: ☐ 90 days ☐ 180 days Duration of Benefits: ☐ 2 yrs ☐ 5 yrs ☐ to age 65

☐ **Critical Illness Benefit**** Max. Benefit Option: ☐ $10,000 ☐ $25,000* ☐ $50,000*

☐ **Supplemental Accident**** ☐ with Disability ☐ without Disability

*Benefit amounts over $10,000 are subject to group size and industry classification. Please confirm with your sales representative.
**These Optional benefits will be Non-Voluntary (Company funded)

Additional Insurance Products

☐ **Business Options** (Includes Property, Business Interruption, Public Liability, Employer's Liability, Money and Worker's Compensation)

☐ **Office Options** (Package policy for offices covering Property, Business Interruption and Liability Risks)

☐ **Contractors' Insurance**

☐ **Workers' Compensation**

☐ **Professional Indemnity**

☐ **Directors & Officers Liability**

☐ **Road User Commercial Vehicle**

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PART 4 KNOWN MEDICAL CONDITIONS

The following questions should be answered to the best of your knowledge for all employees and their dependents to be insured. Please answer Yes or No giving details on any questions to which you have answered Yes on the accompanying spreadsheet.

A. Has anyone been treated for, or shown symptoms of illness, or had surgery in the past five years? (e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness). ☐ Yes ☐ No

B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past? (e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.) ☐ Yes ☐ No

C. Has anyone had a claim of $20,000 or more in the past 12 months? (Include a copy of detailed claims reports, if available.) ☐ Yes ☐ No

D. Is anyone apt to have a continuing claim for a mental or physical disorder? ☐ Yes ☐ No

E. Has anyone been advised to have surgery or diagnostic testing in the last six months or anticipate hospitalization for any other reason? ☐ Yes ☐ No

F. Has any employee missed 10 or more consecutive days of work in the past 12 months due to an illness or injury? ☐ Yes ☐ No

G. Are there any spouses or other dependents who are confined at home, incapacitated or confined in a hospital or treatment facility? ☐ Yes ☐ No

H. Are there any employees who are not actively at work performing their duties full time, due to illness or injury? ☐ Yes ☐ No

I. Are there any employees or dependents now not insured who have been declined for life or medical cover? ☐ Yes ☐ No

PART 5 GROUP CENSUS

Please complete the accompanying spreadsheet with the requested details on each of the employees and their dependents who you wish to insure, including details on any "Yes" responses from Part 4 - Known Medical Conditions.

PART 6 DATA PROTECTION DECLARATION

By signing this form, I confirm/understand that:

- In order to administer the policy and plan Coralisle Medical Insurance Company Ltd. may process any and all of the personal data provided.
- I consent to Coralisle Medical Insurance Company Ltd. processing my personal data, in accordance with Coralisle Medical Insurance Company Ltd.'s Privacy Policy (https://international.cgcoralisle.com/privacy-policy/). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to Coralisle Medical Insurance Company Ltd. in respect of any third party, is done with that third party's consent and knowledge of Coralisle Medical Insurance Company Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Client Name _____ Signature _____ Date _____

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda
PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

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