CG | INSURANCE

GROUP INSURANCE APPLICATION

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 parts 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 _____

Physical Address - Building Name: _____

Street No. and Name: _____

Town/Parish/City: _____ Postal Code: _____ Country: _____

Mailing Address (☐ same as Physical address) - Building Name: _____

Street No. and Name: _____

Town/Parish/City: _____ Postal Code: _____ Country: _____

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 ☐ $10,000 ☐ $25,000* ☐ $50,000*

☐ **Supplemental Accident Benefit**** **These Optional benefits will be Non-Voluntary (Company funded)

*Benefit amounts over $10,000 are subject to group size and industry classification. Please confirm with your sales representative.

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 % _____

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) _____

7. Please supply the following documentation as required:

- ☐ The Entity's certificate of incorporation, trade and business license, charter, constitution, Memorandum and/or Articles of Association or equivalent 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
- ☐ 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.
- ☐ Certified 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
- ☐ Original copy of Register of Directors / Director and Officer Listing (i.e. Certificate of Incumbency) as applicable
- ☐ Original copy of Register of Shareholders/Members disclosing ultimate beneficial ownership as applicable

In addition to the basic requirements noted above, if your company type is a Charity, Association, Trust or Partnership please contact Coralisle Medical for further guidance on required documentation.

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. Approval of insurance coverage is subject to our internal review procedures and the submission of all required documents.

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

e. 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;

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

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

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

i. Coralisle Medical Insurance Company Ltd. may request additional information based on the nature of the application.

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.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

PART 5 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 6 SALES REPRESENTATIVE

Sales Representative Name:_____

Signature of Sales Representative: _____ Date: _____

PART 7 GROUP CENSUS

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

PART 8 NOTES, COMMENTS AND/OR QUESTIONS