

## 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:  \$25,000  \$50,000  \$100,000
- Supplemental Accident\*

\* These Optional benefits will be:  Voluntary (Employee funded) OR  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 Catheterisation, 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 3 - Known Medical Conditions.

### PART 6 COMMENTS