

**Premier Health**

To be completed by the employer for any additional employees and/or dependents, terminated employees or removed dependents or to detail any changes to employee information. Please complete, sign and email to [medical\\_admin\\_bm@cgcoralisle.com](mailto:medical_admin_bm@cgcoralisle.com) or fax to 441-295-9036.

Group Name \_\_\_\_\_ Group No. \_\_\_\_\_

Employee (Emp) Name	Certificate No.	Add* Emp Dep	Delete** Emp Dep	Amend Emp Dep	Effective Date dd/mm/yy	Dependent (Dep) Full Name	Relation***	New Salary
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Other/Additional Info:

\*Must be accompanied by a fully-completed Employee Enrolment Card    \*\*Please return all issued Insurance ID Cards    \*\*\*If adding a working spouse, please name their employer

## Premier Health

### SECTION 3 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.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_