

Premier Health

Internal Use Only Initial & Date	BMI <input type="checkbox"/>	Underwriting <input type="checkbox"/>	Approved for Processing <input type="checkbox"/>	Administrator <input type="checkbox"/>	Audit <input type="checkbox"/>	Plan Election	Other
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PART 1 POLICY DETAILS (To be completed by the Employer)

Group Name _____ Plan Type Premier Provident HIP Enhanced HIP
 PolicyNo. _____ Certificate No. _____

PART 2 EMPLOYEE/INDIVIDUAL DETAILS

Surname _____ First Name _____ Initials _____
 Home Mailing Address _____
 Tel. No(s) _____ Email _____
 Position/Job Title _____ Employment Date (DD/MM/YY) _____
 Annual Salary _____ Male Female Marital Status Single Married Divorced Widowed
 Date of Birth (DD/MM/YY) _____ Height _____ ft. _____ in. Weight _____ lbs. _____ oz.
 Spouse's Name _____ Spouse's Employer _____

Beneficiary(ies) Name	DOB	Relationship	Mailing Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update Beneficiary details at any time.
 If Beneficiary is under 18, please name a Guardian/Trustee. _____

PART 3 MEDICAL HISTORY - EMPLOYEE (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? Answer YES or NO.
 If you answer YES to any of these questions, please give details in Part 6, stating the relevant question number.

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

Premier Health

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

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

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

Patient Name	Question No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Physician Name & Address
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	

PART 7 OPTIONAL EXTRA BENEFITS Confirm with your Employer if these benefits are available and under what terms.

- Critical Illness Supplemental Life Supplemental Accident (please ensure Beneficiary info is provided on page 1)

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PART 8 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any, from my pay. I also 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 LTD. 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 for whom insurance is being requested. Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, Coralisle Medical reserves the right to restrict or revoke cover.

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.

Employee's Signature _____ Date _____

Employer's Signature _____ Date _____