

Solus Health

PART 1 PRIMARY INSURED'S DETAILS

Surname _____ First Name _____ Initials _____
 Date of Birth (DD/MM/YY) _____ Height _____ in. Weight _____ lbs.
 Position/Job Title _____ Male Female
 Country of Citizenship _____
 Address _____
 Home Phone _____ Cell Phone _____
 Email (Work) _____ (Home) _____

PART 2 COVERAGE DETAILS

All selected Coverage is for: Myself Only Myself plus my Spouse Myself plus my Child(ren) Myself plus my Family
 Selected Coverage Benefits: Major Medical Dental Insurance Vision Insurance
 Payment Option: Annual Semi-Annual (plus 3% Service Fee) Quarterly (plus 6% Service Fee)
 Effective Date 1st day of _____ 20____

*Beneficiary(ies) Name	Date of Birth	Relationship	Mailing Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update your Beneficiary details.

If a named Beneficiary is under 18, please name a Guardian/Trustee. _____

PART 3 MEDICAL HISTORY OF PRIMARY INSURED 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? Check YES or NO.

If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

1. Heart..... <input type="checkbox"/> YES <input type="checkbox"/> NO	7. Thyroid, Goiter..... <input type="checkbox"/> YES <input type="checkbox"/> NO	13. Nervous-Mental Disorder..... <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Hypertension, Abnormal Blood Pressure..... <input type="checkbox"/> YES <input type="checkbox"/> NO	8. Kidney Stones, Kidney Problems..... <input type="checkbox"/> YES <input type="checkbox"/> NO	14. Neurological Disorder, Central Nervous Disorder..... <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Cancer, Tumour or Other Growth..... <input type="checkbox"/> YES <input type="checkbox"/> NO	9. Urinary/Reproductive System..... <input type="checkbox"/> YES <input type="checkbox"/> NO	15. HIV/Aids/Aids-related Disease..... <input type="checkbox"/> YES <input type="checkbox"/> NO
4. Allergies..... <input type="checkbox"/> YES <input type="checkbox"/> NO	10. Ortho Problems (Back, Joints, etc.) .. <input type="checkbox"/> YES <input type="checkbox"/> NO	16. Substance Abuse (Drug/Alcohol Dependency, Abuse, Addiction) <input type="checkbox"/> YES <input type="checkbox"/> NO
5. Lungs, Asthma, Bronchitis, Tuberculosis..... <input type="checkbox"/> YES <input type="checkbox"/> NO	11. Stomach/Intestines..... <input type="checkbox"/> YES <input type="checkbox"/> NO	
6. Diabetes..... <input type="checkbox"/> YES <input type="checkbox"/> NO	12. Hernia..... <input type="checkbox"/> YES <input type="checkbox"/> NO	

17. Have you had any drug(s) prescribed during the past three years?..... YES NO
 18. Have you been a patient in a hospital or similar institution during the past three years?..... YES NO
 19. Have you been examined by or consulted a doctor during the past three years?..... YES NO
 20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?..... YES NO
 21. Have you been advised to have a surgical operation or procedure but did not do so?..... YES NO
 22. Have you any known physical impairments, deformities or ill health not covered above?..... YES NO
 23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?..... YES NO
 24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY) _____ LMP date? _____ YES NO
 25. Do you or your dependent(s) have medical coverage with another health insurer?..... YES NO
 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?..... YES NO
 If yes, please provide the name of the employer _____ effective date _____ and/or term date _____

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

Full Name (please print)	Address (if different from Insured)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

PART 5 MEDICAL HISTORY OF 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? Please tick YES or NO

If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

- | | | | | | |
|---|---|---|---|--|---|
| 1. Heart..... | YES NO | 7. Thyroid, Goiter | YES NO | 13. Nervous-Mental Disorder | YES NO |
| 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/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, 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"/> | 26. Have you ever had coverage with Coralisle Medical Insurance? | <input type="checkbox"/> <input type="checkbox"/> | If yes, please provide the name of the health insurer: _____ and effective date: _____ | |
| | | | | If yes, please provide the name of the employer _____ effective date _____ and/or term date _____ | |

PART 6 MEDICAL HISTORY DETAIL

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

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PART 7 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Premier Health individual plan from Coralisle Medical. I 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 LIMITED 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 on whom insurance is being requested. I understand that my insurance will cease only at the end of the Premium Period and that there will be no pro-rata refund of premium. **Furthermore, I understand that should I non-disclose or misrepresent any information, either intentionally or negligently, 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.

Primary Insured's Signature _____ Date _____