CG | INSURANCE

EMPLOYEE ENROLMENT FORM

☐ Change of Details Only

Premier Health

Internal Use Only Initial & Date	BMI ____ ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other

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
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?	☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?	☐	☐
24. If female, are you pregnant? - If Yes, what is your due date? (DD/MM/YY) _____ LMP Date? _____	☐	☐
25. Do you or your dependent(s) have medical coverage with another health insurer?	☐	☐
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?	☐	☐
If Yes, please provide the name of the employer _____ effective date _____ and/or term. date _____		

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

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EMPLOYEE ENROLMENT FORM

Premier Health

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
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?	☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?	☐	☐
24. If female spouse, are you pregnant? - If yes, what is your due date? (DD/MM/YY)_____ LMP Date? _____	☐	☐
25. Do you have medical coverage with another health insurer?	☐	☐
If yes, please provide the name of the health insurer: _____ and effective date: _____		
26. Have you ever had coverage with Coralisle Medical Insurance?	☐	☐
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 ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

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)

PART 8 DECLARATION

I hereby apply for the benefis 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.

Employee's Signature _____ Date _____

Employer's Signature _____ Date _____

You may on occasion be contacted by a company within the Coralisle Group with offers/information in respect of other Coralisle products. We confirm that only your contact details will be made available to Coralisle Group personnel for such purposes and that your private information will not be transferred between Coralisle Group companies or to any other third parties without your consent to do so. If you DO NOT wish to be contacted in this manner by Coralisle Group personnel, please check here ☐. Note that unless you check this box, Coralisle will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.

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Health Insurance and Employee Benefits

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