CGINSURANCE

ENROLMENT FORM

Solus Health

	D'S DETAILS	Eirct Name	、 、			In	vitiale	
Surname								
Date of Birth (DD/MM/YY)								_IDS.
Position/Job Title						Male 🛛	Female 🗖	
Country of Citizenship								
Address								
Home Phone			Cell Phor	ie				
Email (Work)			(Home)					
PART 2 COVERAGE DETA	LS							
All selected Coverage is for: 🛛 My	self Only 🛛 🛛	lyself plus my	Spouse] Myself p	lus my Chi	d(ren) 🛛 N	Ayself plus my Fai	mily
Selected Coverage Benefits: 🗖	Major Medical	🗖 Dental Ins	urance [Vision Ir	nsurance			
Payment Option: 🛛 Annual 🗖	Semi-Annual (olus 3% Servi	ce Fee) 🛛] Quarter	ly (plus 6%	6 Service Fe	ee)	
Effective Date 1st day of		20	_					
*Beneficiary(ies) Name	Date of Birth	Relationship		Mailing	Address		Tel. No.	%
If naming more than one Benefic	iarv. % amount	ts must total 1	100%. Cor	ntact us to	o update v	our Benefic	iarv details.	
If a named Beneficiary is under 18	-						-	
PART 3 MEDICAL HISTOR	-							
						-	-	
Have you at any time been treate		-			-	-		
If you answer YES to any of the	YES NO	cions, piease	give deta		ES NO	the relevan		S NO
1. Heart		Thyroid, Goiter .				lervous-Ment		
2. Hypertension, Abnormal Blood Pre	ssure 🗖 🗖 8. k	Kidnev Stones						
		dancy stories,	Kidney Pro	blems	14. N	leurological I	Disorder, Central	
3. Cancer, Tumour or Other Growth		Jrinary/Reprod	uctive Syst	em		lervous Disor	rder	
4. Allergies		Jrinary/Reprod Ortho Problem	uctive Syst is (Back, Jc	em ints, etc.)	□ □ N □ □ 15. H	lervous Disor IIV/Aids/Aids	rder	
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ENROLMENT FORM

Solus Health

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. YES NO YES NO YES NO 2. Hypertension, Abnormal Blood Pressure 🗆 🗖 8. Kidney Stones, Kidney Problems....... 🗖 14. Neurological Disorder, Central 4. Allergies...... 5. Lungs, Asthma, Bronchitis, Tuberculosis. 🔲 🗖 11. Stomach/Intestines...... 🔲 🗖 16. Substance Abuse (Drug/Alcohol 6. Diabetes...... Dependency, Abuse, Addiction).... C 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 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

Patient Name	Ques. No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Name & Address of Physician
		Date Diagnosed:		On-going 🗖	
		Date Diagnosed:		On-going 🗖	
		Date Diagnosed:		On-going 🗆	
		Date Diagnosed:		On-going 🗆	
		Date Diagnosed:		On-going 🗖	

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.

Primary Insured's Signature

You may on occasion be contacted by a company within the Coralisle Group with offers and/or information in respect of other Coralisle Group products. We confirm that only your contact details will be available to Coralisle Group personnel for such purposes and that your private information will not otherwise 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 \Box . Note that unless you check this box, Coralisle will consider and operate on the basis that you provided your consent to the exchange of your contact details only between Coralisle personnel for the limited and specific purposes described above.

Coralisle Medical Insurance Company Ltd. Jardine House, 33-35 Reid Street, Hamilton HM 12, Bermuda PO Box HM 1559, Hamilton HM FX, Bermuda | Tel 441 296 3200 | Fax 441 295 9036 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

Rev. 08-20

Date