

**PLEASE COMPLETE IN BLOCK LETTERS – ALL QUESTIONS MUST BE ANSWERED**  
(Note: The information on this form is treated as confidential)  
**THIS APPLICATION WILL BE VALID FOR THIRTY (30) DAYS FROM THE DATE OF SIGNATURE**

Retired

SECTION A – APPLICANT INFORMATION						
Last Name		Date of Birth <small>DD/MM/YYYY</small>	Gender <small>Tick one</small>	Height <small>ft/m in/cm</small>	Weight <small>lb kg</small>	IMMIGRATION STATUS <input type="checkbox"/> Caymanian/ Status Holder <input type="checkbox"/> Work Permit Holder <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other _____
First Name			<input type="checkbox"/> Male			
Middle Name			<input type="checkbox"/> Female			
Postal Address			Current Residential Address			
Occupation	Email Address		Cellular	Work Tel	Fax	
Beneficiary Name		Date of Birth <small>(DD/MM/YYYY)</small>	Relationship		Postal Address	Telephone

SECTION B – EMPLOYER INFORMATION			
Name		Email Address	Office Tel
Postal Address		Physical Address	
Current Insurance Carrier		Policy ID	Effective Date <small>(DD/MM/YYYY)</small>
			Est. Termination Date <small>(DD/MM/YYYY)</small>

SECTION C(i) – ELIGIBLE DEPENDENTS									
I. Please provide the required information on dependents to be COVERED (Dependents must reside in the Cayman Islands)									
Name	Date of Birth <small>(DD/MM/YYYY)</small>	Gender <small>(M/F)</small>	Relationship	Height <small>Feet/inches</small>	Weight <small>Lbs/Oz</small>	Current Employer <small>(If applicable)</small>	Employer's Current Health Insurance Carrier	Effective Date of Insurance	Immigration Status
1									
2									
3									
4									

SECTION C(ii) – ELIGIBLE DEPENDENTS, INCLUDING APPLICANT			
1. Are medical benefits available from any other approved insurer to any person listed above, <b>including Applicant</b> (Section A &/or Section C)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information:			
Name	Approved Insurer	Effective Date <small>(DD/MM/YYYY)</small>	Telephone

2. Has any person listed above, <b>including Applicant</b> (Section A &/or Section C) had continuous coverage for a period of not less than one year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information:			
Name	Approved Insurer	Effective Date <small>(DD/MM/YYYY)</small>	Telephone

SECTION D – MEDICAL QUESTIONNAIRE - Please answer questions 1 to 15 for all persons requesting coverage		
In the last twelve months has any person listed above (Section A &/or Section C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:		
1. Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptoms regarding circulatory system or heart. ....	Yes <input type="checkbox"/>	No <input type="checkbox"/>

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>Yes</b>               | <b>No</b>                |
| 2. Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction (stroke), Alzheimer's disease (dementia) and/or other symptoms regarding the neurological system, which if referred to a doctor would result in a diagnosis. .... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptoms regarding the liver, which if referred to a doctor would result in a diagnosis. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Kidney/Renal disease or failure. ....  | <input type="checkbox"/> | <input type="checkbox"/> |

In the last twelve months has any person listed above (Section A &/or Section C) ever:

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 6. Been treated for Cancer? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Been treated for Diabetes (sugar)/Hypertension (high blood pressure)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Been treated for Respiratory conditions? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Had an organ transplant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Had major surgery? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you currently on medications? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Females only: Are you pregnant? If yes, please specify the number of weeks gestation _____ (Last LMP (DD/MM/YYYY) _____): ..... | <input type="checkbox"/> | <input type="checkbox"/> |

Has any approved insurer within the last twelve months:

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 13. Declined an application for health insurance? .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Required an increased premium or imposed special conditions? .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Cancelled or refused to renew an existing health insurance policy? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

16. Where any Question 1 through 15 was answered with a "Yes", please provide details below:

Question No.	Name of Applicant/Dependent	Date of Diagnosis (DD/MM/YYYY)	Reason/Diagnosis	Treatment	Name, Address, Tel and Fax # of Medical Physician/Facility

(If necessary, please provide additional information on a separate page and attach it to this form)

**DECLARATION AND AUTHORISATION**

**I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.**

**I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to Cayman First Insurance Company Limited.**

**A photocopy of this signed authorization shall be as valid as the original.**

**I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.**

**I understand and agree that coverage shall not become effective until accepted by Cayman First Insurance.**

**I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.**

Requested Effective Date (DD/MM/YYYY)	Applicant's Full Name	Applicant's Signature	Date (DD/MM/YYYY)	Spouse's Full Name	Spouse's Signature	Date (DD/MM/YYYY)
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**FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID.**

**SECTION E – VERIFICATION by Policyowner/Group Administrator (If applicable)**

I certify that this form was completed and signed in my presence, and that all the responses given are true and accurate to the best of my knowledge.

Requested Effective Date (DD/MM/YYYY)	Annual Salary of Applicant <small>(if applying for Group Life &amp;/or Disability)</small>	Date (DD/MM/YYYY)	<u>Print</u> Name of Policyowner's Representative	Signature
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**SECTION F – VERIFICATION by Broker (If applicable)**

I certify that all the responses given are true and accurate to the best of my knowledge.

\_\_\_\_\_ Date (DD/MM/YYYY)      \_\_\_\_\_ Print Name of Broker's Representative      \_\_\_\_\_ Signature

Broker's Stamp

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Approved/Declined Stamp

**FOR CAYMAN FIRST'S USE ONLY**

Underwriter's comments

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TO BE COMPLETED BY POLICY RECORDS					
Member ID	Plan Selection	Effective Date (DD/MM/YYYY)	Date entered in Plexis (DD/MM/YYYY)	Date ID card printed (DD/MM/YYYY)	Initials

To Whom It May Concern:

Your insurance cover includes coverage for insureds (primary insureds and/or dependents) under the policy. We collect and use relevant information about insureds to provide coverage and for mandated legal purposes. This information includes sensitive personal details including name, address and medical history.

We will process insureds' details, as well as any other personal information provided, in respect of your insurance coverage, in accordance with our Cayman First Insurance Data Protection Statement, a copy of which is available online at [www.caymanfirst.com/dataprotectionstatement](http://www.caymanfirst.com/dataprotectionstatement) or upon request.

**Please sign below acknowledging that you have read and understood the above statement:**

<b>Applicant</b> Print Full Name	Signature	Date (DD/MM/YYYY)
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<b>Spouse</b> (if spouse is being covered) Print Full Name	Signature	Date (DD/MM/YYYY)
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**CFI DP Statement**