



Looking After Life since 1847
A Member of the Guardian Holdings Group
MEDICAL INSURANCE PLAN

**Arranged by Caribbean Insurers (Health) Limited
APPLICATION FOR GROUP MEMBERS**

Choose a Plan:

Nemwil Health Plan

Nemwil Plus Plan

First Choice Plan

Group Name		Group Number	Effective Date
Employee's Last Name	First Name		Middle Initial
Employee's Address			Social Security No.
Employee's Occupation		Date of Employment	
HEALTH ENROLLMENT			
I wish to enroll for health coverage for:	Myself	My Spouse	My Dependent Children

EMPLOYEE AND DEPENDENT INFORMATION

Name (First, Middle Initial, Last)	Sex	DATE OF BIRTH			Age Last	Birth Place State	Height	Weight
		Mo	Day	Year	B-Day			
Employee								
Spouse								
Child								
Child								
Child								
Child								

I hereby request group insurance for myself and, if the plan provides dependants insurance, for my indicated above. I hereby authorize my employer or successor to make deduction from my salary of the required contributions, if any, to apply toward the premiums the insurance provided for in the group policy issued to my employer by Carib Care.

I understand that eligible dependants are the husband or wife and children from 14 days up to 19 years. This coverage is extended from 19 to 25 years of age, for unmarried, full time students, who must submit evidence of student status before Coverage is provided.

I request membership to the group plan, as indicated above, for which I am, or may become eligible. I agree, if admitted, to the deduction of the appropriate contribution from my pay, and to produce evidence of age if required.

I hereby declare that all statements and all answers to the above questions are complete and true to my knowledge.

I understand that if I and/or my dependants decline coverage and desire to participate in the plan at a later date, evidence of insurability satisfactory to Carib Care must be supplied.

I hereby represent and agree that all the answers and statements in this application are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in denial of an otherwise valid and voiding or reformation of insurance.

Employee Signature _____

Date _____

CARIBBEAN INSURERS (HEALTH) LIMITED
Box 129, Road Town
Tortola, British Virgin Islands

STATEMENT OF HEALTH

ALL QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON TO BE COVERED.	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1. Have you ever received treatment or joined an organisation for alcoholism or drug addiction?						
2. Do you have a personal physician? If yes, please state:						
3. Are you, your spouse, or proposed insured dependants pregnant:?						
4. Have you used tobacco in any form during the past 12 months? If yes, frequency:						
5. Have you used cocaine, marijuana, heroin or any other illicit drug?						
6. Do you consume alcoholic beverages? If yes, type, amount and frequency:						
7. Do you participate in any hazardous sports?						
HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
8. Epilepsy, nervous breakdown, or any disorder of the brain or nervous system?						
9. High blood pressure, dizziness, shortness of breath, pain or pressure in the chest?						
10. Any disorder of the heart or blood vessels?						
11. Tuberculosis or any disorder of the lungs, bronchial tubes, throat, or respiratory system?						
12. Allergies, hay fever, or asthma?						
13. Ulcer, colitis, or any disorder of the stomach, intestines, rectum, gall bladder, or liver?						
14. Hemorrhoids or rectal polyps, or any disorder of the prostate?						
15. Sugar or albumin or blood in urine, or any disorder of the kidneys, urinary system, female or male organs?						
16. Diabetes, gout, or any disorder of the thyroid or other glands?						
17. Any disorder of the eyes, skin, muscle, bones or joints?						
18. Cancer, tumor, or cyst?						
19. Any disorder of the ears, including otitis media?						
20. Acquired Immune deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?						
21. Treatment for infertility, miscarriage, or abortion?						
22. Any disorder or injury involving the spine?						
23. Are you covered by workers compensation?						
DURING THE PAST FIVE YEARS, HAVE YOU:	Employee		Spouse		Children	
	Yes	No	Yes	No	Yes	No
24. Consulted, been examined, or been treated by any physician or practitioner:						
25. Had an X-ray, electrocardiogram, or any laboratory test or study?						
26. Had observation or treatment at a clinic, hospital, or sanitarium?						
27. Had or been advised to have a surgical operation?						
28. Consulted a psychiatrist or psychologist?						
29. Received medical treatment for any disease, condition, or disorder not indicated above?						
30. Are you using regular medication? Please give details of medication						

Below give details of any "YES" answers to questions 1-30 (Use additional paper if necessary)

QUESTION NUMBER	NAME	ILLNESS OR INJURY	DATES OF TREATMENT	DATE OF RECOVERY	NAME OF PHYSICIAN AND/OR HOSPITAL

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE.

To all Underwriters at Lloyd's medical or dental services or supplies and their representatives, the Medical Information Bureau, Inc., or other organisation, or an insurers medical or hospital service plans, prepaid health plans, employers, group policyholders/contractholders. For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish Caribbean Insurers (Health) Limited and its reinsurers or its representatives performing business or legal functions, any information available about the medical history, condition, and treatment for myself, or the Dependants named in this Application.

I authorize Underwriters of Lloyd's and Caribbean Insurers (Health) Limited and its reinsurers to use such information and to redisclose it for the above purposes to its representatives, the Medical Information Bureau, Inc., or other organisation, my employer, union, group contract holder and their representatives, any insurer, medical or hospital service plan, prepaid health plan, or reinsurer. I also authorize Caribbean Insurers (Health) Limited to redisclose such information to any attending physician for treatment purposes, and when necessary to inform the employee of the reason insurance was declined to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, to any person who has an authorisation specifically permitting the redisclosure and as may be permitted or required by law. I agree that this authorisation is valid from the date below and a photocopy shall be as valid as the original. I know that I have a right to ask for and receive a copy of this authorisation.

DATE _____

EMPLOYEE SIGNATURE _____

WITNESS SIGNATURE _____