



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

Choose a Plan:

Nemwil Health Plan

Nemwil Plus Plan

First Choice Plan

MEDICAL PLAN

Arranged by Caribbean Insurers (Health) Limited

APPLICATION FOR INDIVIDUALS

Name (First, Middle Initial, Last)	Sex	DATE OF BIRTH			Age Last B-Day	Birth Place State	Height	Weight	Social Security Number
		Mo	Day	Year					
Proposed Insured:									
Spouse:									
Child:									
Child:									
Child:									
Child:									
Telephone Number	Fax Number		COVERAGE INCLUDES:						
			Major Medical		Prescriptions	Dental	Vision		
Mailing Address									
Employer			Occupation			Duties			
Spouse			Occupation			Duties			

HEALTH DECLARATION

ALL QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON TO BE COVERED.

Provide details to "Yes" answers in next section of this application. Please circle the specific disease.

ALL QUESTIONS ARE TO BE ANSWERED FOR EACH PERSON TO BE COVERED.	Insured		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1. Have you ever received treatment or joined an organization 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:	Insured		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:	Insured		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 AND ACKNOWLEDGEMENT STATEMENT

I hereby apply for health insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions and I agree that the insurance provided only covers the applicant and the dependants listed above who are accepted. I have read the answers to the questions before signing this application and the answers are correctly written as given by me and to the best of my knowledge; true and complete. I understand and agree that no coverage shall be in force until the Certificate is issued, that coverage will be in force as of the effective date shown in the Certificate.

I also acknowledge receipt of the NOTICE TO PROPOSED INSURED and the PRE-NOTICE. A photographic copy of this authorization and acknowledgement shall be as valid as the original.

I understand that no Agent is authorized to change or notify in any way any applicable coverage section of the Certificate or suppress any Company's requirement. No Insurance will be effective until the premium of this Certificate have been paid. I ALSO AGREE that the Medical Information Bureau, or other organization, institution or person or its reinsurers that have any records or knowledge of me or my health, or my dependants listed in this application, to give to CARIB CARE and its reinsurers any such information.

_____	_____	_____
Place	Date	Signature of Proposed Insured
_____	_____	_____
For Caribbean Insurers (Health) Limited		Date

CARIBBEAN INSURERS (HEALTH) LIMITED
P O Box 129
Road Town
Tortola, BVI

TEL: 284-494-8927
FAX: 284-494-8929
E-MAIL: cihl@caribbins.com

Comments of the Insurer:

Premium:
Deductible:
Requested Effective Date: