CG | ATLANTIC MEDICAL & LIFE

GROUP INSURANCE APPLICATION

Premier Health

This Application relates to: ☐ New Business ☐ Amendment to Existing Business*: Policy No._____

*If requesting an Amendment to an existing Group Contract, please complete only those areas in which the information is changing.

PART 1 EMPLOYER DETAILS

Company Name _____

Trade Name_____

VAT TIN _____ Business License No. _____

Mailing Address _____

Registered Office Name and Street Address _____

_____

Address of principal place of business (☐ as above) _____

_____

Contact Person _____ E-mail _____

Phone No. _____ Fax No. _____

Agent _____ Broker _____

Type of Business _____ Effective Date _____

Organisation Type ☐ Partnership ☐ Trust ☐ Foundation ☐ Charity ☐ Private Company ☐ Public Company
☐ Other Fund (specify): _____ ☐ Other (specify) _____

Organisation Operations ☐ Local ☐ International ☐ Listed on stock exchange (which exchange?) _____

Description and Nature of the Business/Trust/Partnership etc. _____

_____

Organisation Website_____

Are you now, or have you ever been, a client of a Coralisle Group Ltd. affiliated Company? (Refer to Appendix 1)
☐ No ☐ Yes If Yes, what other Coralisle Group Products do you have/have you had?

☐ Motor Insurance ☐ Home Insurance: ☐ Building ☐ Contents
☐ Travel Insurance ☐ Business Insurance ☐ Life Insurance: ☐ Group ☐ Individual
☐ Pension ☐ Medical Insurance ☐ Other_____

Total number of employees _____ Total number of dependents _____ Total number aged 65 years and over _____

PART 2 TYPE OF COVER REQUESTED

☐ Medical Plan Benefit ☐ Premier Health ☐ Provident Plan ☐ Self-Funded ☐ Deductible: $_____ ☐ OOP: $_____

☐ Dental Plan Benefit Effective Date: _____ ☐ Basic ☐ Comprehensive

☐ Vision Plan Benefit Effective Date: _____

☐ Life Benefit (Salary to be listed on Census) ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Dependent Life Benefit ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Supplemental Life Benefit

☐ Accidental Death & Dismemberment Benefit ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ Short Term Disability Benefit ☐ ____% of Salary ☐ Flat Amount $ _____ ☐ Sickness _____ Days
☐ Accident: ___ Days ☐ Maximum Amount $ _____ ☐ Maximum Period _____

☐ Long Term Disability Benefit ☐ ____% of Salary ☐ Max Per Month - $ _____ ☐ Maximum Period _____
☐ Waiting Period _____ Days

☐ Critical Illness Benefit** Max. Benefit ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ Supplemental Accident Benefit** ** These Optional benefits will be: ☐ Voluntary (Employee funded) OR ☐ Non-Voluntary (Company funded)

CG | ATLANTIC MEDICAL & LIFE

GROUP INSURANCE APPLICATION

Premier Health

PART 3 KNOW YOUR CUSTOMER (KYC) REQUIREMENTS

Note: The Insurance Commission of the Bahamas Anti-Money Laundering, Combating the Financing of Terrorism and Proliferation Financing (AML-CFT-PF) Guidelines along with local legislation require the insurer to Know Your Customer (KYC) and perform Customer Due Diligence (CDD). In order to comply with this requirement, individual and corporate clients are requested to submit various verification documents to support their application. Accordingly, all prospective policyholders are therefore required to complete the following information and provide the requested supporting documentation.

1. Purpose of the account, source of funds and the estimated account activity:______________________________

   ____

   ____

2. The term "Politically Exposed Person" or "PEP" is a natural person who is or has been entrusted with prominent public functions, their immediate family members and persons known to be close associates of such persons e.g. Heads of State, Members of Parliament, Judicial Officers, Directors, Officers, Principal Representative and Executives of Statutory Boards, Senior Government Officials, Senior Diplomats etc. Does this description apply to any of the Entity's beneficial owners, directors, settlors and/or signatories? ☐ Yes ☐ No

   If Yes, please state the Name, Position and relationship with the PEP (includes inter alia, spouse, partner, siblings, children and their spouses, parents and joint beneficial ownership in an entity):

   ____

3. Please list of all Beneficial Owners of the Organisation with 10% or more ownership (use additional sheet if necessary):

Name	Email	Ownership %

Note: Please include a certified copy of Register of Shareholder.

4. Please list all Directors/Officers/Trustees or equivalent (use additional sheet if necessary):

Name	Email	Title

Note: If the Organisation is a Trust, please provide the name of the Protector/Controller: ____________________

5. Please list Authorized Signatories (individuals who are to issue instructions on the Organisation's behalf) (use additional sheet if necessary):

Name	Email	Signature	Date

Premier Health

6. Please confirm how we should accept instructions/requests from the Organisation: ☐ Any 1 signatory ☐ Any 2 signatories

   ☐ Other method of authorization (please specify) _____

7. Please supply the following documentation. These basic requirements are mandatory for all clients:

   ☐ A certified copy of the Entity's certificate of incorporation or other appropriate documentation, such as a charter or constitution establishing the commencement of the Entity.

   ☐ A certified copy of a valid business license.

   ☐ A list of relevant persons holding a senior management position.

   ☐ The Entity's valid VAT certification documentation.

   ☐ Letter (on client letterhead) confirming that the Entity has not been struck off the register or in the process of being wound up.

   ☐ Board resolution (printed on the Entity's letterhead) authorizing the opening of the account with CG Atlantic Medical & Life Insurance Ltd. and conferring the authorized individual(s) who will operate the account.

   ☐ Provide completed KYC Individual Information Forms for any controlling person (i.e. Beneficial Owner, Director/Trustee, Trust Protector/Controller and any Authorized Signatory), including a certified copy of a Photo ID and Proof of Address.

   ☐ Proof of physical business address such as utility bill or bank or credit card statement (not more than 90 days old) in the Entity's name

   ☐ A certified copy of the Entity's memorandum and articles of association (if applicable).

   In addition to the basic requirements, Charities/Associations must also attach:

   ☐ A letter indicating the Charity/Organization is registered, and the Charity Registration Number.

PART 4 DECLARATION

In connection with this application to CG Atlantic Medical & Life Insurance Ltd., the applicant agrees and understands that:

a. Insurance on any individual shall not take effect until the effective date of the policy;

b. Insurance for which proof of insurability is required will not become effective until insurability is approved by CG Atlantic Medical & Life Insurance Ltd.;

c. CG Atlantic Medical & Life Insurance Ltd. reserves the right to restrict or revoke cover should any of the application or enrollment materials contain any misrepresentations;

d. The information contained in this application is, to the best of the applicant's knowledge, true and complete;

e. The Agent/Broker whose name appears below is the applicant's Agent of Record.

I/We hereby declare that to the best of my/our information knowledge and belief, the information provided above are true and correct, and no material fact has been misrepresented, misstated or withheld. I understand that this KYC form shall be incorporated into and shall constitute a part of the policy contract between me/us and CG Atlantic Medical & Life Insurance Ltd. I/We agree to advise the Company of any changes whatsoever that could affect the operation of the plan and subsequently, our relationship.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

PART 5 CONFIDENTIALITY CLAUSE

I/We also understand that all information provided will be kept confidential and CG Atlantic Medical & Life Insurance Ltd. will abide by the provisions of the Data Protection (Privacy of Personal Information) Act, 2007.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

CG | ATLANTIC MEDICAL & LIFE

GROUP INSURANCE APPLICATION

Premier Health

PART 6 AGENT/BROKER INFORMATION

Agent/Broker's Name: _____

Statement of Agent/Broker: I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted. To the best of my knowledge and belief, all statements in the Application for Group Insurance are true and complete. I have read and I understand the form.

Signature of Agent/Broker: _____ Date: _____

PART 7 SALES REPRESENTATIVE

Sales Representative Name: _____

Signature of Sales Representative: _____ Date: _____

PART 8 GROUP CENSUS

Please use the supplied spreadsheet to provide the Group's Census details.

PART 9 COMMENTS/QUESTIONS

APPENDIX I CG ENTITIES

- ☐ CG Atlantic Insurance Agents & Brokers Ltd.
- ☐ Coralisle Pension Services (Bahamas) Ltd. (formerly Colonial Pensions Services (Bahamas) Limited)
- ☐ Coralisle Insurance Company Ltd.
- ☐ Coralisle Medical Insurance Company Ltd.
- ☐ Coralisle Life Assurance Company Ltd.
- ☐ CG Atlantic Medical & Life Insurance Ltd.

CG Atlantic Medical & Life Insurance Ltd.
Atlantic House, 2nd Terrace & Collins Avenue | PO Box SS-5915, Nassau, Bahamas | Tel 242 326 8191 | Fax 242 326 8189
Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442
www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

A member of Coralisle Group Ltd.

Rev. 01-22