CG	ATLANTIC
	MEDICAL & LIFE

Premier Health

Surname	PART 1 EMPLOYEE'S DETAILS						
Contact Nos	Surname First Name _		N	Middle Initial(s)			
Group Name/No.	Address						
Position/Job Title	Contact NosEmail						
Male Female Marital Status Single Married Divorced Widowed Legally Separated PART 2 TYPE OF CHANGE REQUESTED (please tick all that apply) 1 Change coverage to: Member only Member & Spouse Member & Child Member & Child Family 2 Add a Dependent (Please provide details in the chart below. An Enrolment Form with Dependents details fully completed is also required.) If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (oD/MM/YY)	Group Name/No	Certificate No					
PART 2 TYPE OF CHANGE REQUESTED (please tick all that apply) 1 Change coverage to: Member only Member & Spouse Member & Child Member & Children Family 2 Change coverage to: Member only Member & Spouse Member & Child Member & Children Family 3 Change coverage to: Member only Member & Spouse Member & Child Member & Children Family 4 Change adopted child, please attach a copy of the Adoption Certificate and give date of adoption fading a child with a different last name, please include a copy of their Birth Certificate. 5 Remove a Dependent (Please provide details in the chart below.) If removing a family member, give reason and effective date:	Position/Job Title	Date of Birth (DD/MM/YY)					
Change coverage to: Member only Member & Spouse Member & Child Member & Children Family Add a Dependent (Please provide details in the chart below. An Enrolment Form with Dependents details fully completed is also required.) If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (DD/MM/YY) If adding an adopted child, please attach a copy of the Adoption Certificate and give date of adoption If adding a child with a different last name, please include a copy of their Birth Certificate. Remove a Dependent (Please provide details in the chart below.) If removing a family member, give reason and effective date: Added/Removed Dependent(S) (Surroume, First Name, Initials) Added/Removed Dependent(S) (Surroume, First Name, Initials) Cov/MM/YY) At Change address to address noted in Part 1. Change name from to name noted above. (Please attach supporting documentation proving name change.) PART 3 SIGNATURES Signature of Employee Signature of Employee Service Code: Effective Date of Coverage: Coverage: Coverage CG Atlantic Medical & Life Insurance Ltd.	□ Male □ Female Marital Status □ Single □ Marri	ed 🛛 Divorce	d 🛛 Widowed	Legally Separated			
2. Add a Dependent (Please provide details in the chart below. An Enrolment Form with Dependents details fully completed is also required.) If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (DD/MM/YY)	PART 2 TYPE OF CHANGE REQUESTED (please tick all that apply)						
completed is also required.) If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (DD/MM/YY)	1. 🗆 Change coverage to: 🗆 Member only 🗖 Member & Spouse 🗖 Member & Child 🗖 Member & Children 🗖 Family						
If adding an adopted child, please attach a copy of the Adoption Certificate and give date of adoption If adding a child with a different last name, please include a copy of their Birth Certificate. 3. □ Remove a Dependent (Please provide details in the chart below.) If removing a family member, give reason and effective date: Added/Removed Dependent(s) (summe, First Name, Initials) Date of Birth Relationship (DD/MM/YY) 4. □ Change address to address noted in Part 1. 5. □ Change name from to name noted above. (Please attach supporting documentation proving name change.) PART 3 SIGNATURES Signature of Employee Date Signature of Employee Date Cor OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.							
If adding a child with a different last name, please include a copy of their Birth Certificate.	If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (DD/MM/YY)						
3. Remove a Dependent (Please provide details in the chart below.) If removing a family member, give reason and effective date: Added/Removed Dependent(s) (Surname, First Name, Initials) Date of Birth Relationship (DD/MM/YY) Added/Removed Dependent(s) (Surname, First Name, Initials) Date of Birth Relationship (DD/MM/YY) (DD/M/YY) (DD/M/YY) (DD/M/YY) (DD/M/YY) (DD/M/YY) (DD/M/YY) (Do/M/YY) (Date (Part 3 SIGNATURES Signature of Employee Service Code: Effective Date of Coverage: (CG Atlantic Medical & Life Insurance Ltd.	If adding an adopted child, please attach a copy of the Adoption Certificate and give date of adoption						
If removing a family member, give reason and effective date: Added/Removed Dependent(\$) (Surname, First Name, Initials) Date of Birth Relationship (DD/MM/YY) (DD/MM/YY) 4. Change address to address noted in Part 1. 5. Change name from to name noted above. (Please attach supporting documentation proving name change.) PART 3 SIGNATURES Signature of Employee Date Signature of Employee Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.	If adding a child with a different last name, please include a co	py of their Birtl	n Certificate.				
Added/Removed Dependent(s) (Surname, First Name, Initials) Date of Birth (DD/MM/YY) Relationship 4. Change address to address noted in Part 1.	3. Remove a Dependent (Please provide details in the chart b	elow.)					
(DD/MM/YY) Image: Constraint of the system of the	If removing a family member, give reason and effective date: _						
4. Change address to address noted in Part 1. 5. Change name from	Added/Removed Dependent(s) (Surname, First Name, Initials)		Relationship				
5. Change name from							
5. Change name from							
5. Change name from							
(Please attach supporting documentation proving name change.) PART 3 SIGNATURES Signature of Employee Date Signature of Employer Date FOR OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.	4. Change address to address noted in Part 1.						
PART 3 SIGNATURES Signature of Employee Date Signature of Employer Date FOR OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.	5. 🛛 Change name from			o name noted above.			
Signature of Employee Date Signature of Employer Date FOR OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.	(Please attach supporting documentation proving name change.)						
Signature of Employer Date FOR OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd.	PART 3 SIGNATURES						
FOR OFFICE USE Service Code: Effective Date of Coverage: CG Atlantic Medical & Life Insurance Ltd. CG Atlantic Medical & Life Insurance Ltd.	Signature of Employee	Date					
CG Atlantic Medical & Life Insurance Ltd.	Signature of Employer		C	Date			
	FOR OFFICE USE Service Code:	Effective Date o	f Coverage:				
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, Bahamas Tel 242 351 3960 Fax 242 351 7442 www.CGCoralisle.com Health Insurance and Employee Benefits	Atlantic House, 2nd Terrace & Collins Avenue PO Box SS-5915, Nassau, E Suite 7-8, Jasmine Corporate Center PO Box F-42655, Freeport, Bahama						
INSURANCE HEALTH PENSIONS LIFE A member of Coralisle Group Ltd. Rev. 11-21				Rev. 11-21			