ATLANTIC
MEDICAL & LIFE

REQUEST FOR PROPOSAL

Premier Health

The information on this form is designed to assist in evaluating your group. It is therefore essential that the information provided be complete and true to the best of your knowledge.

PART 1 EMPLOYER DETAILS

Company Name ______________________________

Mailing Address ______________________________

Contact Person ____________________ Email ____________________

Phone No. ____________________ Fax No. ____________________

Agent ____________________ Broker ____________________

Type of Business ____________________ Effective Date (DD/MM/YY) ____________________

Current Carrier ____________________ Current Rates ____________________

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

Previous Medical Client? ☐ Yes ☐ No If Yes, previous Policy No.____________ Cancellation Date (DD/MM/YY) ____________

PART 2 TYPE OF COVER REQUESTED

☐ New Business ☐ Change Existing Business: Policy ________________

PART 3 DETAILS OF COVER REQUESTED (tick all that apply)

☐ Medical Plan Benefit ☐ Deductible: $________________ ☐ OOP: $ ________________

☐ Dental Plan Benefit ☐ Basic ☐ Comprehensive

☐ Vision Plan Benefit

☐ Life Benefit (Actual Salary To Be Listed On Census) ☐ Flat Amount of $ ____________ or ☐ Multiple of Salary ____________

☐ Dependent Life Benefit ☐ Flat Amount of $ ____________ 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 ☐ Max Amount $____________ ☐ Maximum Period ____________

☐ Long Term Disability Benefit

☐ ____________ % of Salary ☐ Max Per Month - $ ____________ ☐ Maximum Period - ____________

☐ Waiting Period ____________ Days

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

☐ Supplemental Accident Benefit**

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

PART 4 MEDICAL PROFILE

The following questions must be answered to the best of your knowledge for all employees and their dependents to be insured (proprietors, partners, corporate officers, employees, spouses, and dependent children.)

Place tick Yes or No. Please give details on any questions answered Yes in the separate Census document.

A. Has anyone been treated for, or shown symptoms of illness, or had surgery in the past five years? (e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness). ☐ Yes ☐ No

B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past? (e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.) ☐ Yes ☐ No

C. Has anyone had a claim of $20,000 or more in the past 12 months? (Include a copy of detailed claims reports, if available.) ☐ Yes ☐ No

D. Is anyone apt to have a continuing claim for a mental or physical disorder? ☐ Yes ☐ No

E. Has anyone been advised to have surgery or diagnostic testing in the last six months or anticipate hospitalization for any other reason? ☐ Yes ☐ No

ATLANTIC MEDICAL & LIFE

REQUEST FOR PROPOSAL

Premier Health

F. Has any employee missed 10 or more consecutive days of work in the past 12 months due to an illness or injury? ☐ Yes ☐ No

G. Are there any spouses or other dependents who are confined at home, incapacitated or confined in a hospital or treatment facility? ☐ Yes ☐ No

H. Are there any employees who are not actively at work performing their duties full time, due to illness or injury? ☐ Yes ☐ No

I. Are there any employees or dependents now not insured who have been declined for life or medical cover? ☐ Yes ☐ No

Please complete the following section if you have answered 'Yes' to any of the questions above. Please use an additional sheet if there are more persons with 'Yes' answers for the previous page.

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

Patient Name:	Patient Age:	Question Ref. :
Diagnosis:		
Treatment:		
Prognosis:		
Does the patient currently have insurance? ☐Yes ☐No		

ATLANTIC
MEDICAL & LIFE

Premier Health

PART 5 GROUP CENSUS

	Date of Birth (DD/MM/YY)	Gender	Dependents	Annual Salary	Occupation/Title
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					

Total number of employees _______ Total number of dependents _______ Total number aged 65 years and over ______

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. 11-21