CG | 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: ☐ $10,000 ☐ $25,000* ☐ $50,000*

☐ Supplemental Accident Benefit** ☐ with Disability ☐ without Disability

*Benefit amounts over $10,000 are subject to group size and industry classification. Please confirm with your sales representative.

**These Optional benefits will be 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

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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		

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PART 5 GROUP CENSUS

	Date of Birth (DD/MM/YY)	Gender	Dependents	Annual Salary	Occupation/Title
1					
2					
3					
4					
5					
6					
7					
8					
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32					

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

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PART 6 DATA PROTECTION DECLARATION

By signing this form, I confirm/understand that:

- In order to administer the policy and plan CG Atlantic Medical & Life Insurance Ltd. may process any and all of the personal data provided.
- I consent to CG Atlantic Medical & Life Insurance Ltd. processing my personal data, in accordance with CG Atlantic Medical & Life Insurance Ltd.'s Privacy Policy (https://international.cgcoralisle.com/privacy-policy/). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to CG Atlantic Medical & Life Insurance Ltd. in respect of any third party, is done with that third party's consent and knowledge of CG Atlantic Medical & Life Insurance Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Name: _____ Signature:_____ Date:_____

CG Atlantic Medical & Life Insurance Ltd.
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Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Grand Bahama, Bahamas | Tel 242 351 3960 | Fax 242 351 7442 |
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