



Solus Health

PART 1 PRIMARY INSURED'S DETAILS

Surname _____ First Name _____ Initials _____

Gender Male Female Marital Status Single Married Divorced Widowed

Date of Birth (DD/MM/YY) _____ Height _____ ft. _____ in. Weight _____ lbs. _____ oz.

Position/Job Title _____ Employer _____

NIB No. _____ Country of Citizenship* _____

Residential Address _____

Mailing Address _____

Tel. No(s) _____ Email _____

Electronic Funds Transfer (EFT): Please supply the following Employee details in order to be reimbursed for any Claim payments.

Bank Name _____ Name on Bank Account _____

ABA Number _____ Bank Account No. (incl. Transit) _____

I (and my insured dependents) am ordinarily resident within The Bahamas (i.e. reside for 9 months+ per year) Yes No

*If Country of Citizenship is not The Bahamas, please provide proof of permission to reside in The Bahamas. Attached

PART 2 COVERAGE DETAILS

Coverage is for: Myself Only Myself plus my Spouse Myself plus my Child(ren) Myself plus my Family

Coverage Level: \$500 Deductible \$2,000 Deductible Life Insurance: \$10,000 \$25,000

Life Insurance Beneficiary(ies) Name	Date of Birth (DD/MM/YY)	Relationship	Mailing Address	Email Address	Tel. No.	%

If naming more than one Beneficiary, % amounts must total 100%. Contact us to update Beneficiary details at any time.

If Beneficiary is under 18, please name a Guardian/Trustee. _____

Payment Option: Annual Semi-Annual Quarterly Requested Effective Date: _____

PART 3 MEDICAL HISTORY - EMPLOYEE (Please complete if requesting benefits for yourself)

Have you at any time been treated for, or been told that you had trouble with, any of the following? Answer YES or NO.

If you answer YES to any of these questions, please give details in Part 6, stating the relevant question number.

- | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| YES NO | YES NO | YES NO |
| 1. Heart..... <input type="checkbox"/> <input type="checkbox"/> | 7. Thyroid, Goiter..... <input type="checkbox"/> <input type="checkbox"/> | 13. Nervous-Mental Disorder..... <input type="checkbox"/> <input type="checkbox"/> |
| 2. Hypertension, Abnormal Blood Pressure. <input type="checkbox"/> <input type="checkbox"/> | 8. Kidney Stones, Kidney Problems..... <input type="checkbox"/> <input type="checkbox"/> | 14. Neurological Disorder, Central Nervous Disorder..... <input type="checkbox"/> <input type="checkbox"/> |
| 3. Cancer, Tumour or Other Growth..... <input type="checkbox"/> <input type="checkbox"/> | 9. Urinary/Reproductive System..... <input type="checkbox"/> <input type="checkbox"/> | 15. HIV/Aids/Aids-related Disease <input type="checkbox"/> <input type="checkbox"/> |
| 4. Allergies..... <input type="checkbox"/> <input type="checkbox"/> | 10. Ortho Problems (Back, Joints, etc.).... <input type="checkbox"/> <input type="checkbox"/> | 16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction). <input type="checkbox"/> <input type="checkbox"/> |
| 5. Lungs, Asthma, Bronchitis, Tuberculosis.. <input type="checkbox"/> <input type="checkbox"/> | 11. Stomach/Intestines..... <input type="checkbox"/> <input type="checkbox"/> | |
| 6. Diabetes..... <input type="checkbox"/> <input type="checkbox"/> | 12. Hernia..... <input type="checkbox"/> <input type="checkbox"/> | |
| 17. Have you had any drug(s) prescribed during the past three years?..... <input type="checkbox"/> <input type="checkbox"/> | | |
| 18. Have you been a patient in a hospital or similar institution during the past three years?..... <input type="checkbox"/> <input type="checkbox"/> | | |
| 19. Have you been examined by or consulted a doctor during the past three years?..... <input type="checkbox"/> <input type="checkbox"/> | | |



Solus Health

- 20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?.....
- 21. Have you been advised to have a surgical operation or procedure but did not do so?.....
- 22. Have you any known physical impairments, deformities or ill health not covered above?.....
- 23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified? ..
- 24. If female, are you pregnant? - If Yes, what is your due date? (DD/MM/YY) _____ LMP Date? _____

PART 4 DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) (Complete if requesting benefits for eligible dependents)

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

PART 5 MEDICAL HISTORY - DEPENDENT(S) (Please complete if requesting benefits for your eligible dependents)

Have you at any time been treated for, or been told that you had trouble with, any of the following? Answer YES or NO. If you answer YES to any of the following questions, please give details in Part 6 stating the relevant question number.

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| YES NO | YES NO | YES NO |
| 1. Heart..... <input type="checkbox"/> <input type="checkbox"/> | 7. Thyroid, Goiter..... <input type="checkbox"/> <input type="checkbox"/> | 13. Nervous-Mental Disorder <input type="checkbox"/> <input type="checkbox"/> |
| 2. Hypertension, Abnormal Blood Pressure. <input type="checkbox"/> <input type="checkbox"/> | 8. Kidney Stones, Kidney Problems <input type="checkbox"/> <input type="checkbox"/> | 14. Neurological Disorder, Central Nervous Disorder <input type="checkbox"/> <input type="checkbox"/> |
| 3. Cancer, Tumour or Other Growth <input type="checkbox"/> <input type="checkbox"/> | 9. Urinary/Reproductive System..... <input type="checkbox"/> <input type="checkbox"/> | 15. HIV/Aids/Aids-related Disease <input type="checkbox"/> <input type="checkbox"/> |
| 4. Allergies <input type="checkbox"/> <input type="checkbox"/> | 10. Ortho Problems (Back, Joints, etc.).. <input type="checkbox"/> <input type="checkbox"/> | 16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)... <input type="checkbox"/> <input type="checkbox"/> |
| 5. Lungs, Asthma, Bronchitis, Tuberculosis .. <input type="checkbox"/> <input type="checkbox"/> | 11. Stomach/Intestines..... <input type="checkbox"/> <input type="checkbox"/> | |
| 6. Diabetes..... <input type="checkbox"/> <input type="checkbox"/> | 12. Hernia..... <input type="checkbox"/> <input type="checkbox"/> | |
| 17. Have you had any drug(s) prescribed during the past three years? <input type="checkbox"/> <input type="checkbox"/> | | |
| 18. Have you been a patient in a hospital or similar institution during the past three years? <input type="checkbox"/> <input type="checkbox"/> | | |
| 19. Have you been examined by or consulted a doctor during the past three years? <input type="checkbox"/> <input type="checkbox"/> | | |
| 20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so? <input type="checkbox"/> <input type="checkbox"/> | | |
| 21. Have you been advised to have a surgical operation or procedure but did not do so?..... <input type="checkbox"/> <input type="checkbox"/> | | |
| 22. Have you any known physical impairments, deformities or ill health not covered above?..... <input type="checkbox"/> <input type="checkbox"/> | | |
| 23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified? . <input type="checkbox"/> <input type="checkbox"/> | | |
| 24. If female spouse, are you pregnant? - If yes, what is your due date? (DD/MM/YY) _____ LMP Date? _____ <input type="checkbox"/> <input type="checkbox"/> | | |

PART 6 MEDICAL HISTORY DETAIL If you answered YES to any question in Part 3 or 5, please provide details here.

Patient Name	Question No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Physician Name & Address
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	
		Date Diagnosed:		On-going <input type="checkbox"/>	

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PART 7 DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Solus Health individual plan from CG Atlantic Medical & Life Insurance Ltd. I authorize any attending physician, surgeon, clinic, hospital, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to CG Atlantic Medical & Life Insurance Ltd. or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent on whom insurance is being requested. Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, CG Atlantic Medical reserves the right to restrict or revoke cover.

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.

Primary Insured's Signature _____ Date _____

Dependent Spouse's Signature _____ Date _____

Dependent Child's Signature (age 19+ only) _____ Date _____

Internal Use Only	BMI <input type="checkbox"/>	Underwriting <input type="checkbox"/>	Approved for Processing <input type="checkbox"/>	Administrator <input type="checkbox"/>	Audit <input type="checkbox"/>	Plan Election	Other
Initial & Date							

CG Atlantic Medical & Life Insurance Ltd.

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Health Insurance and Employee Benefits

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