

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 Parts in which the information is changing.

PART 1 EMPLOYER DETAILS

Company Name _____

Mailing Address _____

Street Address _____

Contact Person - Admin. _____ E-mail _____

Phone No. _____ Fax No. _____

Contact Person - Billing _____ E-mail _____

Monthly statement to be emailed. **Note:** Statements can be sent to up to 3 contacts. If desired, please advise 2 more recipients:

Email2 _____ Email3 _____

Agent _____ Broker _____

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

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: _____

What other CG products do you have? 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 Deductible/Out of Pocket option: _____
 Provident Caribbean LTM: \$2M or \$1M Deductible/Out of Pocket option: _____
 CarePlus Plan

Dental Plan Benefit Effective Date (DD/MM/YY): _____

Vision Plan Benefit Effective Date (DD/MM/YY): _____

Group Life Benefit (Actual Salary* to be listed on the supplied Spreadsheet)

Flat Amount \$ _____ OR Multiple of *Salary _____ Max. Benefit _____

Supplemental Life Benefit** _____

Dependent Life Benefit Flat Amount for Spouse \$ _____ Flat Amount for Child \$ _____

Accidental Death And Dismemberment Benefit (AD&D) (Actual Salary* to be listed on the supplied Spreadsheet)

Flat Amount \$ _____ OR Multiple of *Salary _____ Max. Benefit _____

Short-Term Disability Benefit (Actual Salary* to be listed on the supplied Spreadsheet)

_____ % of *Salary Flat Amount - \$ _____ Sickness - _____ Days

Accident - _____ Days Maximum Amount - \$ _____ Maximum Period - _____

Long-Term Disability Benefit For Long-Term Disability, a separate application form is required.

Critical Illness Benefit** Max. Benefit \$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)

Health Insurance

PART 3 DECLARATION

In connection with this application to CG United 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 Coralisle Medical Insurance Company Ltd.;
- c. Approval of insurance coverage is subject to our internal review procedures and the submission of all required documents;
- d. CG United Insurance Ltd. reserves the right to restrict/revoke cover should any of the application or enrollment materials contain any misrepresentations;
- e. The information contained in this application is, to the best of the applicant's knowledge, true and complete;
- f. The Agent/Broker whose name appears over is the applicant's Agent of Record.

Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan CG United Insurance Ltd. may process any and all of the personal data provided.
- I consent to CG United Insurance Ltd. processing my personal data, in accordance with CG United 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 United Insurance Ltd. in respect of any third party, is done with that third party's consent and knowledge of CG United 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 of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

PART 4 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 5 SALES REPRESENTATIVE

Sales Representative Name: _____

Signature of Sales Representative: _____ Date: _____

PART 6 GROUP CENSUS

Please use the separate Spreadsheet provided to submit the required details for your Group's Employees.

CG United Insurance Ltd.

Administered by Coralisle Medical Insurance Company Ltd.

www.CGCoralisle.com

Members of Coralisle Group Ltd.

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