ATLANTIC MEDICAL

PremierHealth

Please select one:
New Employee ☐
Change Employee Details ☐
Add/Change Dependent Details ☐

ENROLMENT FORM

I POLICY/PLAN DETAILS

Policy Number _____ Certificate No. /NIB No. _____

Employer _____

Plan Type: Medical ☐ Dental ☐ Vision ☐ AD&D* ☐ LTD ☐ STD ☐ Dep Life ☐ Life* ☐ Benefit Amount _____

II EMPLOYEE/INDIVIDUAL DETAILS

Surname _____ First Name _____ Initials _____

Coverage Desired (check one): Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family ☐

Position/Job Title _____ Date of Employment (MM/DD/YY) _____ Annual Salary _____

Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Country of Citizenship _____

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

Spouse's Name _____ Spouse's Employer _____

Home Mailing Address _____

Telephone No(s) _____ Email _____

Electronic Funds Transfer (EFT) **Details**: Please supply the following Employee information in order to be reimbursed for any Claim Payments:

Bank Name _____ Name on Bank Account _____

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

*Life/AD&D Beneficiary(ies) Name	Date of Birth	Relationship	Mailing Address	Tel. No.	%

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

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

III MEDICAL HISTORY - EMPLOYEE If you answer YES to any of the following questions for yourself, please give details in Section VI.

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

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes and Related Problems	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary System/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
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 or modified?	☐	☐
24. If female, are you pregnant? - If yes, what is your due date? (MM/DD/YY) _____ LMP date? (MM/DD/YY) _____	☐	☐
25. Do you or your dependent(s) have medical coverage with another health insurer?	☐	☐
If yes, please provide the name of the health insurer: _____ and effective date: _____		
26. Have you or your dependents ever had coverage with Atlantic Medical Insurance?	☐	☐
If yes, please provide the name of the employer _____ effective date _____ and/or term date _____		
27. Are you waiving dependent coverage?	☐	☐
If yes, what is the reason? _____		

IV DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) (Please complete if requesting benefits for your eligible dependents)

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth (MM/DD/YY)	Effective Date (MM/DD/YY)

Internal Use Only	BMI ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other
Initial & Date							

V MEDICAL HISTORY - DEPENDENT(S) If you answer YES to any of the following questions for your Dependent(s), give details in Section VI.

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

	YES	NO		YES	NO		YES	NO
1. Heart	☐	☐	7. Thyroid, Goiter	☐	☐	13. Nervous-Mental Disorder	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐	8. Kidney Stones, Kidney Problems	☐	☐	14. Neurological Disorder, Central Nervous Disorder	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary System/Reproductive System	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐			
6. Diabetes and Related Problems	☐	☐	12. Hernia	☐	☐			

17. Have you had any drug(s) prescribed during the past three years? ☐ ☐
18. Have you been a patient in a hospital or similar institution during the past three years? ☐ ☐
19. Have you been examined by or consulted a doctor during the past three years? ☐ ☐
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 or modified? ☐ ☐
24. If female, are you pregnant? - If yes, what is your due date? (MM/DD/YY) _____ LMP date? (MM/DD/YY) _____ ☐ ☐
25. Do you have medical coverage with another health insurer? ☐ ☐
    If yes, please provide the name of the health insurer: _____ and effective date: _____
26. Have you ever had coverage with Atlantic Medical Insurance? ☐ ☐
    If yes, please provide the name of the employer _____ effective date _____ and/or term date _____

VI MEDICAL HISTORY DETAIL If you answered YES to any questions in Section III or V, please provide details here.

Patient Name	Question No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Physician Name & Address
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

VII DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any from my pay. I also 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 ATLANTIC MEDICAL INSURANCE LIMITED 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, Atlantic Medical reserves the right to restrict or revoke cover.**

Employee's Signature _____ Date _____

Dependent Spouse's Signature _____ Date _____

Dependent Child's Signature (over 19 years only _____ Date _____

Employer's Signature _____ Date _____

You may on occasion be contacted by a company within the Colonial Group with offers/information in respect of other Colonial Group products. We confirm that only your contact details will be made available to Colonial Group personnel for such purposes and that your private information will not be transferred between Colonial Group companies or to any other third parties without your consent to do so. If you **DO NOT** wish to be contacted in this manner by Colonial Group personnel, please check here ☐. Note that unless you check this box, Colonial will consider and operate on the basis that you have provided your express consent to the exchange of your contact details only between Colonial Group personnel for the limited and specific purposes described above.