ATLANTIC MEDICAL

Health Insurance

GROUP INSURANCE APPLICATION

I EMPLOYER DETAILS

Company Name _____

VAT Tin _____

Mailing Address _____

Contact Person _____ E.Mail _____

Phone No _____ Fax No. _____

Agent _____ Broker _____

Type of Business _____ Effective Date _____

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

II TYPE OF COVER REQUESTED

☐ **Medical Plan Benefit** ☐ PremierHealth ☐ ProvidentPlan ☐ Self-Funded Plan ☐ Deductible: $ _____ ☐ OOP: $ _____

☐ **Dental Plan Benefit** Effective Date: _____ ☐ Basic ☐ Comprehensive

☐ **Vision Plan Benefit** Effective Date: _____

☐ **Life Benefit** (Salary to be listed on Census) ☐ Flat Amount $ _____ OR ☐ Multiple of Salary _____

☐ **Dependent Life Benefit** ☐ Flat Amount $ _____ 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 ☐ Maximum Amount $ _____ ☐ Maximum Period _____

III DECLARATION

In connection with this application to Atlantic Medical Insurance, 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 Atlantic Medical;
c. Atlantic Medical reserves the right to restrict or revoke cover should any of the application or enrollment materials contain any misrepresentations;
d. The information contained in this application is, to the best of the applicant's knowledge, true and complete;
e. The Agent/Broker whose name appears below is the applicant's Agent of Record.

Name of Applicant: _____ Title or Position: _____

Signature of Applicant: _____ Date: _____

IV 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: _____

V GROUP CENSUS

Please use the supplied spreadsheet to provide the Group's Census details.

VI COMMENTS/QUESTIONS

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