ATLANTIC MEDICAL

SolusHealth

ENROLMENT FORM

I PRIMARY INSURED'S DETAILS

Surname _____ First Name _____ Initials _____

Date of Birth (DD/MM/YY) _____ Height _____ in. Weight _____ lbs. ☐ Male ☐ Female

Position/Job Title _____ Employer _____

Country of Citizenship* _____ National Insurance No. _____

Mailing Address _____

Residential Address _____

Home/Cell Phone _____ Email _____

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

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

II 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)	Date of Birth (DD/MM/YY)**	Relationship	Mailing Address	Tel. No.	%***

**If under 18, please name Guardian/Trustee. ***If naming more than one Beneficiary, % amounts must total 100%. Contact us at any time to update your Beneficiary details.

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

III MEDICAL HISTORY OF PRIMARY INSURED 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? Please tick YES or NO.

If you answer YES to any of the following questions, please give details in section VI stating the relevant question number.

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes & 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 been prescribed any drugs during the past 3 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, modified?	☐	☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY) _____ LMP date? _____	☐	☐

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

Full Name (PLEASE PRINT)	Address	Gender	Height	Weight	Relationship	Date of Birth (DD/MM/YY)	Effective Date (DD/MM/YY)

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

V MEDICAL HISTORY OF DEPENDENT(S) Please complete if requesting benefits for any eligible Dependents

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

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes & 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 been prescribed any drugs during the past 3 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, modified?	☐	☐
24. If female, are you pregnant? - If yes, what is your due date? (DD/MM/YY) _____ LMP date? _____	☐	☐

VI EXPLANATIONS

If you have answered YES to any of the questions under the MEDICAL HISTORY sections for yourself or your depdenents, please explain the details in full here. Attach an extra sheet if necessary.

Patient Name	Ques. No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Name & Address of Physician
		Date Diagnosed:		On-going ☐	
		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 Premier Health individual plan from Atlantic Medical. 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 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.**

Primary Insured's Signature _____ Date _____

Dependent Spouse's Signature _____ Date _____

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