CG | UNITED

GROUP INSURANCE APPLICATION

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 Coralisle Group 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:_____

☐ **Dental Plan Benefit** Effective Date (DD/MM/YY): _____ ☐ Comprehensive ☐ Basic

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

☐ **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 - _____

☐ **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)

PART 3 DECLARATION

In connection with this application to Coralisle Medical Insurance Company 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;
c. Coralisle Medical reserves the right to restrict/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 over is the applicant's Agent of Record.

Premier Health

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 REPRSENTATIVE

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.

PART 7 NOTES, COMMENTS &/OR QUESTIONS