Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

The group division of Family Guardian Insurance Company Limited

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INDIVIDUAL APPLICATION FORM

Group Number: _____

ID Number: _____

1. Policyholder's Name:	2. Employer:	3. Occupation:	4. National Ins. #:
5. Mailing & Street Address:	6. Telephone: Work:	Home:	Cell:
	7. Email:		
8. Birth Date: mm/dd/yyyy	9. Height: _____ Weight: _____	11. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	
	10. Sex: ☐ Male ☐ Female	Name of Primary Care Physician:	
12. Select BahamaHealth Plan:	☐ Select _____ ☐ Life _____ ☐ Value _____ ☐ Hospital Plus _____ ☐ Dep. Life _____ ☐ Dental & Vision (Conversion Only) _____ ☐ Dependent Coverage Only _____		
13. Do you or any of the proposed Dependents have major medical health coverage elsewhere?			☐ Yes ☐ No
14. If "Yes", Please Provide Name of Insurance Company:		15. Type of Plan: ☐ Group ☐ Individual	
16. If covered under a Group or Individual Insurance, please provide:	Group/Individual #:		ID#:
17. Type of Coverage: ☐ Single ☐ Family	18. Effective Date: mm/dd/yyyy		19. Coverage End Date: mm/dd/yyyy
20. If applicable, provide names of person(s) covered by that plan:			
21. Please indicate your preferred mode/method of premium payments.	Method: ☐ Credit Card ☐ Salary Deduction ☐ Over the Counter ☐ Online ☐ Postdated Check		
	Mode: ☐ Monthly ☐ Semi-Annual ☐ Annual		
22. If payor differs from Insured please provide the following:	Payor Name: Date of Birth (mm/dd/yyyy): Relationship to Applicant:_____ (Please include a copy of Government Issued Identification) ☐ If coverage is approved or denied, refunds should be made payable to the Payor.		

23. PLEASE INDICATE BELOW OTHER PERSONS APPLYING FOR COVERAGE.

Name	NIB #	Relationship	Gender (Male/Female)	Date of Birth (mm/dd/yyyy)	Name of Physician	Employer	Height	Weight
1.								
2.								
3.								
4.								
5.								

24. IF LIFE COVERAGE IS INCLUDED, PLEASE STATE BENEFICIARY DESIGNATION.
PLEASE INCLUDE A COPY OF A GOVERNMENT ISSUED IDENTIFICATION FOR EACH PERSON

Name of Beneficiary*	Relationship	DOB (mm/dd/yyyy)	%	Name of Beneficiary*	Relationship	DOB (mm/dd/yyyy)	%
1.				3.			
2				4.			

25. *A TRUSTEE MUST BE APPOINTED IF CHILDREN UNDER AGE 18 ARE NAMED AS BENEFICIARIES

Trustee Name:	Relationship:

26. SUBMIT PREMIUM(S) AND APPLICATION FEE WITH APPLICATION. RATES MAY CHANGE AFTER UNDERWRITING.

Application fee (non-refundable) $90.00*

Applicant	$	Dependent 3	$		
Dependent 1	$	Dependent 4	$	Life	$
Dependent 2	$	Dependent 5	$	Dental & Vision**	$

* $90.00 application fee waived for Conversion Applications only.

** Dental and Vision benefits allowed on Conversion Applications only.

*** Charged on Medical, Dental & Vision Products Only.

Sub-Total Medical Products	
Value-Added Tax (VAT)***	$
Life	$
Total Premium Due Plus Application Fee	$
Total Amount Collected	$

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Health Questions - Must be completed

1. Have you or your dependents over the age of 16 ever been treated for the following:

		Yes	No			Yes	No
a.	Heart disease/stroke, chest pain, blood vessel, veins or circulation conditions?	☐	☐	m.	Disease of eye or ear and speech disorder?	☐	☐
b.	Back/bone/joint problems, spine problems?	☐	☐	n.	High blood pressure?	☐	☐
c.	Cancer, tumor, goiter?	☐	☐	o.	Diabetes?	☐	☐
d.	Chronic Diarrhea, digestive or stomach disorders or vomiting?	☐	☐	p.	Medical diagnosis of AIDS or an AIDS - related condition?	☐	☐
e.	Asthma or any disorder of the lungs, throat or nose?	☐	☐	q.	Alcoholism or drug abuse?	☐	☐
f.	Sickle cell, Iron deficieny or any other anemia or hepatitis B?	☐	☐	r.	Tuberculosis or blood spitting?	☐	☐
g.	Varicose veins, circulation problems, arteriosclerosis?	☐	☐	s.	Emotional, mental problems, counseling or brain/nervous disorders?	☐	☐
h.	Pharyngitis, tonsilitis, bronchitis, cough, cold, influenza?	☐	☐	t.	Arthritis, neuritis, rheumatism, rheumatic fever, other disease of the bone or gout?	☐	☐
i.	Disorders of the liver, kidney or bladder, rectum, intestines, ulcers, prostrate or jaundice?	☐	☐	u.	Myasthenia Gravis, muscular dystrophy, multiple sclerosis, muscular disease?	☐	☐
j.	Have you ever had sugar, pus, blood or albumin in urine?	☐	☐	v.	Hodgkin's disease, systemic lupus erythamatosis (SLE)?	☐	☐
k.	Chronic fatique syndrome?	☐	☐	w.	Disorders of the skin or glands or allergies?	☐	☐
l.	Epilepsy / seizures, convulsions, fainting spells, dizziness or paralysis?	☐	☐	x.	Any condition other than those above?	☐	☐

		Yes	No
2.	Within the last 12 months have you or your dependents consulted a physician, therapist, counselors or healthcare providers of any kind for any condition for which any ongoing follow-up treatment is or was required?	☐	☐
3.	Have you or your dependents had any loss of weight, been in a hospital, sanitariums or other institutions for observation or treatment? Had electro-cardiograms, X-Rays, blood studies or other diagnostic tests?	☐	☐
4.	Do you or any of your dependents smoke, or have smoked cigarettes in the last two years? *If yes, add 5% to the premium rate*	☐	☐
5.	Do you or your dependents have any condition (excluding pregnancy) for which a hospital confinement has been advised or is contemplated?	☐	☐
6.	Are you or any of the above Dependents taking prescribed medication?	☐	☐
7.	Are you or any of the above dependents pregnant? If yes, give expected delivery date: _____	☐	☐
8.	Has surgery or treatment for you or any of the above Dependents been advised but not performed?	☐	☐
9.	If the answers to any of questions 1 through 8 is "YES" for you or any of your dependents please provide item number and answer the following questions (use additional pages if necessary).		

Name of Person	Item No.	Date(s) of Treatment (mm/dd/yyyy)	Physician consulted or place of treatment	Symptom, illness or diagnosis	Treatment Received and/or present condition

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PLEASE COMPLETE THIS SECTION IF DEPENDENT(S) ARE AGES 0 - 15 YEARS
(To be completed for each dependent child 0-15)

1a. Name (please print):	b. Date of Birth (mm/dd/yyyy):	c. Age:

2. a. Name of your child's usual doctor, clinic or medical facility (If none, so state) _____
   b. Address _____
   c. When was doctor last consulted (include date) _____
   d. Reason? _____
   e. Treatment? _____
   f. Results? _____

		Yes	No	If question is answered "YES", give full details, dates, name of attending physicians, medical facilities and results facilities and results.
3.	Has the child ever been refused insurance or offered modified or rated insurance in any way?	☐	☐	
4.	Has the child ever suffered from or has a physician been consulted about any disturbance or symptoms pertaining to bladder trouble including frequent or unusual bed wetting?	☐	☐	
5.	Has child ever been immunized? If yes, give details. *Please attach current immunization records.*	☐	☐	
6.	Has the child any congenital defect or was the child born prematurely?	☐	☐	
7.	Does the child suffer from any disease which was acquired from the mother during the course of pregnancy?	☐	☐	
8.	In the past year, has the child suffered from any illnesses or injuries that prevent him/her from attending school for five or more days?	☐	☐	
9.	a. Has the child ever had an X-ray, blood or other special examinations? b. Which? _____ c. Date?_____ d. By whom?_____ e. Reason?_____ f. Result? _____	☐	☐	
10.	Child's height and weight in ordinary clothing Height_____ft._____ins. Weight_____ lbs. Weight gained in past year_____lbs. Weight lost in past year_____lbs. Reason?_____			
11.	Is the child now in good health and free from all symptoms of illness and disease?	☐	☐	
12.	Is the child now taking any medication or treatment?	☐	☐	
13.	Has any member of the child's family (mother, father, brother or sister) ever suffered from diabetes, elevated blood pressure, heart, or kidney disease, mental or nervous disorder, cancer or tuberculosis?	☐	☐	

14.	Age if Living	Age at Death	State of Health	Cause & Date of Death
Father				
Mother				
Brothers & Sisters				
Number Living				
Number Dead				

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BANKING INFORMATION FOR ELECTRONIC FUND TRANSFER FOR CLAIM PAYMENTS

Name of Financial Institution:					
Branch Address:		City:		Island:	
Branch No:	#	Account No:	#		
Type of Account:	☐ Savings ☐ Checking				
Account Holder Name:		Email Address:			

PRE-AUTHORIZED CREDIT CARD PAYMENT PLAN

Please provide a copy of the front of credit card along with a valid Government identification.

I, _____ (Please print name)

hereby authorize Family Guardian to charge $_____ to my credit card number indicated below effective _____ (mm/dd/yyyy)

with respect to Policy number: _____ and on the _____ day of each subsequent month.

Select Card Type:	☐ Visa	☐ American Express	☐ Diner	☐ MasterCard	☐ Discover	☐ SunCard

Card #:		Expiry Date (mm/dd/yyyy):	

These instructions are to remain in effect until cancelled by myself in writing. Additionally, I also authorize Family Guardian/BahamaHealth to adjust the original amount(s), as needed due to subsequent premium increases and/or reductions to ensure full satisfaction of required policy payment(s).

X Signature of Cardholder	Name of Cardholder (Please print name)

Postal Address:		Island:		Email address:	
Telephone:	Work:		Home:		Cell:

X Witness Signature (Must be a Family Guardian representative)	Witness Name (please print name)
Date (mm/dd/yyyy):	

I hereby apply for membership in the BahamaHealth Individual Plan, underwritten and issued by Family Guardian Insurance Co., Ltd., for myself and any eligible dependents. I also certify that the information furnished by me on this application is true and complete to the best of my knowledge and belief. I understand any material omission or misrepresentation may result in termination of enrollment and declining of any claims. I further understand that: (1) I or my dependents may be covered by another insurance and will cooperate fully with BahamaHealth in providing information necessary to coordinate benefits;(2) before issuing the policy, Evidence of Insurability must be provided and that there will be waiting periods for pre-existing conditions and; (3) no agent can guarantee premiums, benefits, and/or coverage; (4) upon underwriting and application approval, coverage will become effective on thefirst day of the month following the date of approval. (5) If coverage is denied, I understand that all premiums will be refunded less application fee to the payor listed.

I authorize any physician, medical practitioner, hospital, clinic, other medically-related facility, consumer reporting agency, insurance or reinsuring company or employer having certain information about my spouse, children, or me to release to Family Guardian Insurance Co. Ltd. or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations, and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness. I also authorize Family Guardian Insurance Co. Ltd., the Company, to release any information obtained to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim or, as may be otherwise lawfully required, or as I may further authorize. This authorization also allows Family Guardian to release copies of all tests completed to the physician noted above in the event of coverage being denied, rated or postponed.

WHEN THIS APPLICATION INCLUDES 2 OR MORE PERSONS:
NO INDIVIDUAL APPLYING UNDER THIS APPLICATION WILL BE APPROVED FOR COVERAGE UNTIL THE UNDERWRITING PROCESS HAS BEEN COMPLETED FOR ALL PERSONS INCLUDED IN THIS APPLICATION.

I agree that a photographic copy of this Authorization shall be as valid as the original.

X Applicant's Signature	Date (mm/dd/yyyy)
X Signature Required For All Dependents Age Eighteen And Over	X Signature Required For All Dependents Age Eighteen And Over

To be completed by the agent:

Name of Agent	Agent Number
X Agent's Signature	Date (mm/dd/yyyy)

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CONDITIONAL RECEIPT

RECEIVED on the conditions set out below from (Name) _____

Name of Insured(s)	Amount	Name of Insured(s)	Amount
1.	$	5.	$
2.	$	6.	$
3.	$	7.	$
4.	$	8.	$

Application Fee: $90.00 Total Due: $ _____

by Cheque/Cash for the FULL FIRST PREMIUM plus APPLICATION FEE ($90.00) specified in the attached BahamaHealth Individual Application with FAMILY GUARDIAN INSURANCE COMPANY LIMITED ("the Company"). The conditions mentioned above are as follows: -

1. The insurance coverage applied for shall become effective on the first day of the month following approval by the Company. Hence, until such approval is given, there shall be no liability on the part of the Company except to return the above premium payment less the application fee. This application should be completed within 60 days after submission.
2. This receipt shall be void if given for a cheque or draft that is not honored on presentation.
3. If the application is declined (in full or in part) the relevant premium shall be returned to the applicant, LESS THE $90.00 APPLICATION FEE.

Dated this _____ day of _____ 20_____

Name of Agent/Broker

Agent/Broker Number

X

Signature of Agent/Broker

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SALARY DEDUCTION PLAN AUTHORIZATION

Employee Name:		Employee No:	
Department:		Address:	
Telephone:	Work:	Home:	Cell:
Month of first deduction:		**If government, pay to CODE #2303**	
Date of new application (mm/dd/yyyy):			

I have applied for a policy of insurance to Family Guardian Insurance Co. Ltd. (BahamaHealth) under an application date as shown above.

I HEREBY AUTHORIZE AND REQUEST my employer, as my agent to deduct each month from my salary, beginning with the Month of First deduction as shown above, the Salary Deduction specified and remit the sum so deducted to Family Guardian Insurance Co. Ltd., as payment on account of the premium under the policy(s) mentioned below.

Dated at _____ this _____ day of _____, 20_____

X _____ X _____

Witness Signature of employee

FOR OFFICE USE

(Please list all new and existing accounts)

Insured's Name	Member Number	Premium Amount
1.		$
2.		$
3.		$
4.		$
5.		$
6.		$
7.		$
8.		$
9.		$
10.		$
11.		$
12.		$
	Total Deduction:	$

[N.B. Weekly premiums should be monthlyized by multiplying the premium by 4.333]

NOTE TO AGENTS: PLEASE COMPLETE FORM IN DUPLICATE AND RETURN STAMPED COPY TO BAHAMAHEALTH.