Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

The group division of Family Guardian Insurance Company Limited

COMPLETE LEGIBLY & IN ENTIRETY • PRINT IN BLOCK CAPITAL LETTERS • LIQUID PAPER IS NOT PERMITTED

APPLICATION FOR GROUP INSURANCE

Name of Applicant or Employer:							
P. O. Box:		Street Address:			City:		
Email Address:			Phone:		Fax:		
Legal Status:	☐ Corporation ☐ Limited Company ☐ Partnership ☐ Sole Proprietorship ☐ Association						
Subsidiaries and Affiliates to be Insured:	Company Name & Address		Contact Person & Title			Subsidiary	Affiliate
	1.					☐	☐
	2.					☐	☐
	3.					☐	☐
Nature of Business:		Name of Group Administrator:			Title:		
Effective Date:	MM	DD	YYYY	Deposit (Required With Application):		$	
Submit Bills to:	☐ Applicant Only ☐ Applicant & Subsidiaries/Affiliates Separately ☐ Other Address _____ *Bills are sent via email; Provide email address* _____						
Submit Claims Reimbursement Cheques:	☐ To Employee's Mailing Address ☐ Sealed and sent to the Employee via Group Administrator ☐ Other *If Claims Address differs from above, please provide here:* _____						
Eligible Employees:					From	To	
	Present: ☐ Covered Immediately ☐ Open Enrollment (Groups of 50+)						
	Future: ☐ Covered Immediately ☐ Covered on the 1st day of the month following ☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 Days of Employment						

1. *A minimum of 5 employees are required for group coverage.*
2. *Eligible Employees and their dependents who do not enroll at the time of the initial effective date of the policy for the group will need to provide evidence of insurability and may be denied coverage. Eligible Employees must be actively at work on the date coverage begins.*
3. *Eligible Employees must work a minimum of 30 hours per week at the employer's customary place of business.*
4. *The waiting period, up to a maximum of twelve (12) months, for Pre-Existing Conditions will apply to Members who have not enrolled as per the eligibility period. That is the member is considered a Late Enrollee.*

Agent or Broker:	Did an agent or broker assist you with this proposal? ☐ Yes ☐ No If yes, please give name: _____
Name of Previous Carrier:	

A copy of your last month's billing statement, reflecting all employees covered, must be attached to this application.

THE APPLICANT hereby declares that the statements and answers contained above are full, complete and true as of the date hereof and expressly agrees that (1) such statements and answers constitute the application and will form part of the contract; (2) the insurance will become effective in accordance with and subject to the policy to be issued to the Applicant, but in no case will it become effective until a) the first monthly premium has been paid, b) this application has been approved by the COMPANY. No agent/broker has the authority to modify any policy, or to waive any of the COMPANY's rights or requirements. Any policy, including any attached riders and amendments, issued on basis of this application shall together with this application constitute a single and entire contract of insurance. Any amendments to this application made by the COMPANY shall be delivered to the APPLICANT at least 30 days prior to the effective date and shall become effective upon acceptance by the APPLICANT.

Dated at _____ day of _____ 20 _____

_____ Name of Agent/Broker	_____ Authorized Signature of Agent/Broker	_____ Title (If applicable)
_____ Name of Employer's Authorized Representative	_____ Signature of Employer's Authorized Representative	_____ Title
_____ Name of Family Guardian's Authorized Representative	_____ Signature of Family Guardian's Authorized Representative	_____ Title

(PLEASE ATTACH COPY OF THE ACCEPTED PROPOSAL)

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Categories of Employee & Dependent Coverage	☐ Employee Only; Employee & Spouse; Employee & Child(ren)); Employee & Family ☐ Employee Only; Employee & One Dependent; Employee & Family ☐ Employee Only; Employee & Family ☐ Employee & One Child ☐ Employee Only ☐ Other _____						
	☐ Retiree ☐ Retiree & Spouse/Family ☐ Other _____						
TYPES OF MEDICAL PLAN:	☐ $1,000,000 ☐ $2,000,000 Special Considerations: _____						
Active Employees:	☐ Choice Plus Executive ☐ Choice Plus ☐ Select ☐ Value ☐ Hospital Plus						
Retired Employees:	☐ Choice Plus Executive ☐ Choice Plus ☐ Select ☐ Value ☐ Hospital Plus						
OTHER BENEFITS:							
Employee Life:	☐ Yes ☐ No Classes:	1.	2.	3.			
	Based on Flat $ Amount(s):	1.	2.	3.			
	Multiples of Annual Salary: ☐ One Times ☐ Two Times ☐ Three Times ☐ Other _____						
	Salary Changes Will Be Advised: ☐ Annually in the Month of _____						
	Maximum Benefit:	1.	2.	3.			
	Guaranteed Issue Amount:						
	Supplemental Life: ☐ Yes ☐ No ☐ Same as Life Benefit ☐ Other, state amount _____						
Employee Accidental Death & Dismemberment:	☐ Yes ☐ No						
Employee Vision:	☐ Yes ☐ No ☐ $400 Annual Benefit ☐ Other Considerations						
Employee Dental:	☐ Yes ☐ No ☐ $1,500 Annual Benefit ☐ $2,000 Annual Benefit ☐ $2,500 Annual Benefit *Annual Dental Benefits that Exceed $1,500 - Groups of 50 or more*						
Employee Long Term Disability:	☐ Yes ☐ No Maximum Monthly Benefit: _____						
	Benefit Percent: ☐ 50% ☐ 60% ☐ 66 $\frac{2}{3}$% ☐ 70%						
	Elimination Period: ☐ 30 ☐ 60 ☐ 90 ☐ 120 ☐ 150 ☐ 180 ☐ 360 days						
	Benefit Duration to Age: _____ Own Occupation Definition: ☐ 24 ☐ 36 ☐ 60 Months						
Dependent Benefits:	☐ Dependent Life $5,000, $2,500, $500 ☐ Dependent Dental ☐ Other Dependent Life Amount _____ ☐ Dependent Vision						

A minimum of 50% of Active Employees' premium and 25% of Retirees' premium for the Standard Plan must be paid by the Employer

50% Of Premium Employer Will Contribute:		Health	Life	AD&D	LTD	Dental	Vision
	Employee Premium:						
	Dependent Premium:						
	Retiree Premium:						