Bahama Health
FEEL GOOD ABOUT YOUR HEALTH PLAN

The group division of Family Guardian Insurance Company Limited

GROUP ENROLLMENT FORM

Complete legibly & in entirety

Print in block capital letters • Liquid paper is not permitted on the form • Amendments are to be initialed

Name of Employer: _____ ID Number: _____

Employee's Legal Name:		**Date of Hire:** (mm/dd/yyyy)	**Division:**
Employee's Street Address:		**Postal Address:**	
Email:		**Tel (Work):**	**Tel (Home):**	**Tel (Cell):**
Birth Date: (mm/dd/yyyy)	**Marital Status:** ☐ Single ☐ Widowed ☐ Legally Separated ☐ Married ☐ Divorced	**Sex:** ☐ Male ☐ Female	

Plan Selected:

☐ Employee Life ☐ Supplemental Life ☐ Dependent Life

☐ Accidental Death & Dismemberment ☐ Long Term-Disability ☐ Short Term Disability

☐ Dental ☐ Vision ☐ Choice Plus Executive _____ ☐ Choice Plus _____

☐ Select _____ ☐ Indemnity ☐ Value _____ ☐ Hospital Plus II _____

Coverage Type:

☐ Employee Only	☐ Employee & Spouse
☐ Employee & Child(ren)	☐ Employee & Family
☐ Retiree Only	☐ Retiree & Family

OTHER CARRIER DETAILS

Are you or any of your dependents that will enroll in BahamaHealth, covered by another group major medical insurance plan? ☐ Yes ☐ No

If yes, please provide name of that insurance company: _____

Group:_____, ID#:_____, Effective Date:(mm/dd/yyyy) _____, Termination Date: (mm/dd/yyyy):_____

Type of coverage: ☐ Single ☐ Family

If applicable, provide names of persons covered by that plan:

Do you or any of your dependents presently have a medical condition for which you will seek services within the next six months? ☐ Yes ☐ No
(e.g. medications, doctor visits, pending surgery, diagnostic testing or procedures)
If 'yes' please state the condition, along with the name and address of the Attending Physician/s, as we wish to ensure the smooth continuation of your care.

The waiting period, up to a maximum of twelve (12) months, for Pre-Existing Conditions will apply to members who have not met the waiting period under the previous group coverage and to new hires. Pre-Existing Condition: "An Illness or Injury for which symptoms have been present or for which a Member has received medical care, treatment or advice at any time during the twelve (12) months before Coverage begins under this Policy. The Company will not cover Eligible Expenses for Covered Services for Pre-Existing Conditions during the first twelve (12) months of continuous Coverage under this Policy.

PLEASE INDICATE BELOW OTHER PERSONS APPLYING FOR COVERAGE

Full Name	NIB #	Relationship	Gender	Date of Birth (mm/dd/yyyy)	Employer	Name of Physician

Is any dependent child listed above over the age of 19? ☐ Yes ☐ No **If yes, is the dependent a full time student?** ☐ Yes ☐ No

A student verification form is to be completed if the dependent is a full time student and age 19 and over.

If life coverage is included, please state beneficiary designations:

Beneficiary	Date of Birth (mm/dd/yyyy)	Relationship	%	Contact Number	Address

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

Trustee Name: _____ **Relationship:** _____

I hereby apply for membership in the BahamaHealth Plan (underwritten and issued by Family Guardian Insurance Co., Ltd.) for myself and any eligible dependents and authorize my employer to make deductions, as required, as my contribution towards the premium. I hereby 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 denial of any claims. I further understand that I or my dependents may be covered by another group insurance and will cooperate fully with BahamaHealth to provide information necessary to coordinate benefits.

I authorize any physician, medical practitioner, hospital, clinic, other medically-related facility, consumer reporting agency, insurance or reinsurance company or employer having certain information about my spouse, children, or by me to release to Family Guardian 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 Company Ltd. 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. I agree that a photographic copy of this Authorization shall be as valid as the original.

_____ _____

Employee Signature Date (mm/dd/yyyy)

TO BE COMPLETED BY EMPLOYER

I hereby confirm that the above employee has been actively employed for at least 30 hours per week since _____ (date of hire: mm/dd/yyyy). I also confirm that this employee was actively at work on the effective date and is eligible to enroll.

Employee Salary:		**NIB #:**		**Enrollment Effective Date:**	
Authorized Signature of Employer:		**Title:**		**Date:** (mm/dd/yyyy)	