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

EVIDENCE OF INSURABILITY
AGES 0 – 15 YEARS

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				