COLONIAL

PremierHealth

EMPLOYEE ENROLMENT FORM

I POLICY DETAILS (To be completed by the Employer)

Policy Number _____ Certificate No. _____

Group Name _____ Plan Type: ☐ Premier ☐ Provident ☐ HIP Enhanced ☐ HIP

II EMPLOYEE DETAILS

Surname _____ First Name _____ Initials _____

Position/Job Title _____

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth (DD/MM/YY) _____ Height _____ ft. _____ in. Weight _____ lbs. _____ oz.

Date of Employment _____ Annual Salary _____

Spouse's Name _____ Spouse's Employer _____

Home Mailing Address _____

Tel. No(s) _____ Email _____

Life Insurance Beneficiary(ies)	Date of Birth	Relationship	Mailing Address	Tel. No.	%

If Beneficiary is under 18, please name a Guardian/Trustee. If naming more than one Beneficiary, % amounts must total 100%. Contact us to update your Beneficiary details.

III MEDICAL HISTORY - EMPLOYEE (Please complete if requesting benefits for yourself)

Have you at any time been treated for or been told that you had trouble with any of the following? Please answer YES or NO.
If you answer YES to any of the following questions, please give details in Section VI, stating the relevant question number.

	YES	NO
1. Heart	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐
4. Allergies	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐
6. Diabetes	☐	☐
7. Thyroid, Goiter	☐	☐
8. Kidney Stones, Kidney Problems	☐	☐
9. Urinary System/Reproductive System	☐	☐
10. Ortho Problems (Back, Joints, etc.)	☐	☐
11. Stomach/Intestines	☐	☐
12. Hernia	☐	☐
13. Nervous-Mental Disorder	☐	☐
14. Neurological Disorder, Central Nervous Disorder	☐	☐
15. HIV/Aids/Aids-related Disease	☐	☐
16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
17. Have you had any drug(s) prescribed during the past three years?	☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?	☐	☐
19. Have you been examined by or consulted a doctor during the past three years?	☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?	☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?	☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?	☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?	☐	☐
24. If female, are you pregnant? - If Yes, what is your due date? (DD/MM/YY) _____ LMP Date? _____	☐	☐
25. Do you or your dependent(s) have medical coverage with another health insurer?	☐	☐
If Yes, please provide the name of the health insurer: _____ and effective date: _____		
26. Have you or your dependents ever had coverage with Colonial Medical Insurance?	☐	☐
If Yes, please provide the name of the employer _____ effective date _____ and/or term. date _____		

Internal Use Only	BMI _____ ☐	Underwriting ☐	Approved for Processing ☐	Administrator ☐	Audit ☐	Plan Election	Other
Initial & Date							

IV DEPENDENT(S) DETAILS FOR SPOUSE, CHILD(REN) (Please complete if requesting benefits for your eligible dependents)

Full Name (please print)	Gender	Height	Weight	Relationship	Date of Birth	Effective Date

V MEDICAL HISTORY - DEPENDENT(S) (Please complete if requesting benefits for your eligible dependents)

Have you at any time been treated for or been told that you had trouble with any of the following? Please answer YES or NO.
If you answer YES to any of the following questions, please give details in Section VI stating the relevant question number.

	YES	NO		YES	NO		YES	NO
1. Heart	☐	☐	7. Thyroid, Goiter	☐	☐	13. Nervous-Mental Disorder	☐	☐
2. Hypertension, Abnormal Blood Pressure	☐	☐	8. Kidney Stones, Kidney Problems	☐	☐	14. Neurological Disorder, Central Nervous Disorder	☐	☐
3. Cancer, Tumour or Other Growth	☐	☐	9. Urinary System/Reproductive System	☐	☐			
4. Allergies	☐	☐	10. Ortho Problems (Back, Joints, etc.)	☐	☐	15. HIV/Aids/Aids-related Disease	☐	☐
5. Lungs, Asthma, Bronchitis, Tuberculosis	☐	☐	11. Stomach/Intestines	☐	☐	16. Substance Abuse (Drug or Alcohol Dependency, Abuse, Addiction)	☐	☐
6. Diabetes	☐	☐	12. Hernia	☐	☐			
17. Have you had any drug(s) prescribed during the past three years?							☐	☐
18. Have you been a patient in a hospital or similar institution during the past three years?							☐	☐
19. Have you been examined by or consulted a doctor during the past three years?							☐	☐
20. Have you been advised to enter a hospital/institution for diagnosis, rest or treatment, but did not do so?							☐	☐
21. Have you been advised to have a surgical operation or procedure but did not do so?							☐	☐
22. Have you any known physical impairments, deformities or ill health not covered above?							☐	☐
23. Have you ever had an application for reinstatement of Life, Accident, or Health Insurance declined, postponed, rated, modified?							☐	☐
24. If female spouse, are you pregnant? - If yes, what is your due date? (DD/MM/YY)_____ LMP Date? _____							☐	☐
25. Do you have medical coverage with another health insurer?							☐	☐
If yes, please provide the name of the health insurer: _____ and effective date: _____								
26. Have you ever had coverage with Colonial Medical Insurance?							☐	☐
If yes, please provide the name of the employer _____ effective date_____ and/or term date_____								

VI MEDICAL HISTORY DETAIL If you answered YES to any questions in Section III or V, please provide details here.

Patient Name	Question No.	Diagnosis	Medications/Treatments	Complete Recovery MM/YY	Physician Name & Address
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	
		Date Diagnosed:		On-going ☐	

VII DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any, from my pay. I also authorize any attending physician, surgeon, clinic, hospital, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to COLONIAL MEDICAL INSURANCE COMPANY LIMITED or its reinsurers any such information. A photographic copy of this authorization shall be as valid as the original. The foregoing shall equally apply to any dependent for whom insurance is being requested. **Furthermore, I understand that should I non-disclose or misrepresent any information for either myself or any dependents, Colonial Medical reserves the right to restrict or revoke cover.**

Employee's Signature _____ Date _____

Employer's Signature _____ Date _____