COLONIAL

PremierHealth

GROUP INSURANCE APPLICATION

I EMPLOYER DETAILS

Company Name ______________________________

Mailing Address ______________________________

Street Address ______________________________

Contact Person - Billing ______________________ E-mail ______________________

☐ Monthly statement to be emailed. **Note:** Statements can be emailed to up to 3 contacts. If desired, please advise two more recipients:

Email2: ______________________ Email3: ______________________

Contact Person - Admin. ______________________ E-mail ______________________

Phone No ______________________ Fax No. ______________________

Agent ______________________ Broker ______________________

Type of Business ______________________ Effective Date (DD/MM/YY) ______________________

Total number of employees ________ Total number of dependents ________ Total number aged 65 years and over ________

II TYPE OF COVER REQUESTED

☐ **Medical Plan Benefit** ☐ Premier Health ☐ Provident Plan ☐ HIP Enhanced ☐ HIP

☐ **Dental Plan Benefit** Effective Date (DD/MM/YY): ______________ ☐ Comprehensive ☐ Basic

☐ **Vision Plan Benefit** Effective Date (DD/MM/YY): ______________

☐ **Group Life Benefit** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ Flat Amount $____________ OR ☐ Multiple of *Salary ____________ Max. Benefit ____________

☐ **Supplemental Life Benefit**** ______________________

☐ **Dependent Life Benefit** ☐ Flat Amount for Spouse $____________ ☐ Flat Amount for Child $____________

☐ **Accidental Death And Dismemberment Benefit (AD&D)** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ Flat Amount $____________ OR ☐ Multiple of *Salary ____________ Max. Benefit ____________

☐ **Short-Term Disability Benefit** (Actual Salary* to be listed on the supplied Spreadsheet)

☐ ________ % of *Salary ☐ Flat Amount - $ ____________ ☐ Sickness - ____________ Days

☐ Accident - ______ Days ☐ Maximum Amount - $ ____________ ☐ Maximum Period - ____________

☐ **Long-Term Disability Benefit** For Long-Term Disability, a separate application form is required.

III DECLARATION

In connection with this application to Colonial Medical Insurance Company Limited, the applicant agrees and understands that:

a. Insurance on any individual shall not take effect until the effective date of the policy;
b. Insurance for which proof of insurability is required will not become effective until insurability is approved by Colonial Medical;
c. Colonial Medical reserves the right to restrict/revoke cover should any of the application or enrollment materials contain any misrepresentations;
d. The information contained in this application is, to the best of the applicant's knowledge, true and complete;
e. The Agent/Broker whose name appears over is the applicant's Agent of Record.

Name of Applicant: ______________________ Title or Position: ______________________

Signature of Applicant: ______________________ Date: ______________________

IV AGENT/BROKER INFORMATION

Agent/Broker's Name: ____________________

Statement of Agent/Broker: I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted. To the best of my knowledge and belief, all statements in the Application for Group Insurance are true and complete. I have read and I understand the form.

Signature of Agent/Broker ____________________ Date: ____________________

V GROUP CENSUS

Please use the separate Spreadsheet provided to submit the required details for your Group's Employees.

VI NOTES, COMMENTS &/OR QUESTIONS

COLONIAL

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