COLONIAL

SolusHealth

INDIVIDUAL INSURANCE ENROLMENT FORM

I PRIMARY INSURED'S DETAILS

Surname ______ First Name ______ Initials ______

Date of Birth (DD/MM/YY) ______ Height ______ in. Weight ______ lbs.

Position/Job Title ______ Male ☐ Female ☐

Country of Citizenship ______

Address ______

Home Phone ______ Cell Phone ______

Email (Work) ______ (Home) ______

II COVERAGE DETAILS

Coverage is for: ☐ Myself Only ☐ Myself plus my Spouse ☐ Myself plus my Child(ren) ☐ Myself plus my Family

Dental Option: ☐ Yes ☐ No Vision Option: ☐ Yes ☐ No

Payment Option: ☐ Annual ☐ Semi-Annual (plus 3% Service Fee) ☐ Quarterly (plus 6% Service Fee)

Effective Date **1st day of ______ 20 ______**

III MEDICAL HISTORY OF PRIMARY INSURED **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		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	☐	☐			

	YES	NO
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							

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INDIVIDUAL INSURANCE ENROLMENT FORM

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

Full Name (please print)	Address (if different from Insured)	Gender	Height	Weight	Relationship	Date of Birth (DD/MM/YY)	Effective Date (DD/MM/YY)

V MEDICAL HISTORY OF DEPENDENT(S)

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 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

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

VI DECLARATION

I hereby apply for the benefits for which I and my dependents (if applicable) am or may become eligible under the Premier Health individual plan from International Benefit Resources and Colonial Medical. I 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 on whom insurance is being requested. I understand that my insurance will cease only at the end of the Premium Period and that there will be no pro-rata refund of premium. **Furthermore, I understand that should I non-disclose or misrepresent any information, either intentionally or negligently, for either myself or any dependents, Colonial Medical reserves the right to restrict or revoke cover.**

Primary Insured's Signature ______________________ Date ______________