CINICO

Health Insurance Policy

APPLICATION FORM

1. Please complete ALL required sections/questions on this document in block letter and indicate N/A where not applicable. 2. Include copies of all the specified and relevant documents.

SECTION A: APPLICANT INFORMATION

1. Last Name:
2. First Name:
3. Middle Name:
4. PO Box No:
5. Postal Code:
6. Gender: ☐ Male ☐ Female
7. Physical Address:
8. District:
9. Email Address:
10. Contact No:
11. Birth Date:
12. Height (ft/in):
13. Weight (lb):
14. Employment Status: ☐ Emlpoyed ☐ Unemployed ☐ Retired

SECTION B: EMPLOYER INFORMATION

15. Employer Name:
16. Employer No:
17. Physical Address:
18. PO Box
19. Postal Code:
20. Email Address:
21. Contact No:

In accordance with Sect. 7 of the Health Insurance Act (2021 Revision), I acknowledge that I am liable to pay the premium with respect of this policy.

22. Employer's Signature:
23. Date:

SECTION C: ELIGIBLE DEPENDANTS INFORMATION

Notes: (i) Dependents not resident in the Cayman Islands are not eligible for coverage.
(ii) Child(ren) includes Dependent Offspring.

	24. Full Name:	25. Gender	26. Birth Date:	27. Relationship:	28. Height (ft/in):	29. Weight (lb):
a)						
b)						
c)						
d)						
e)						

30. Are Medical Benefits available from any other approved insurer for any person listed above (Part A and/or Part C)? ☐ YES ☐ NO

If yes, state the Name and Telephone Number of Approved Insurer:

Insurer Name: Insurer Telephone No:

31. Has any person listed above (Part A &/or Part C) has continuous coverage for a period of not less than one year? ☐ YES ☐ NO

If yes, state the Name and Telephone Number of Approved Insurer:

Insurer Name: Insurer Telephone No:

32. Is your spouse employed? ☐ YES ☐ NO

If yes, state the Name and Telephone Number of your spouse's employer:

Employer Name: Employer Telephone No:

SECTION D(a): MEDICAL QUESTIONNAIRE

In the last (12) twelve months has the Applicant or any Eligible Dependent listed above ever been advised to, or received medical consultation, care, treatment or taken medication in relation to any of the following:

33. Heart or Circulatory System (including but not limited to Infarction, Heart Attack, Angina, Rheumatic Fever, Cardiac Defect, Arrhythmias, diseases of Veins, Arteries or Valves, Stroke) and/or any other symptom regarding Circulatory System or Heart. ☐ YES ☐ NO

34. Sexually Transmitted Diseases or Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) or ARC (AIDS related complex). ☐ YES ☐ NO

34. Neurological System (including but not limited to Convulsions, Epilepsy, Paralysis, Multiple Sclerosis, Cerebral Infarction (stroke), Alzheimer's Disease, Dementia) and/or any other symptom regarding the neurological system, which, if referred to a doctor, would result in a diagnosis. ☐ YES ☐ NO

35. Liver disorders (including but not limited to Fatty Liver, Cirrhosis, Hepatitis) and/or any other symptom regarding the liver, which, if referred to a doctor, would result in a diagnosis. ☐ YES ☐ NO

36. Kidney/Renal disease or failure? ☐ YES ☐ NO

In the last (12) twelve months has the Applicant or any Eligible Dependent listed ever:

37. Been treated for Cancer? ☐ YES ☐ NO

38. Been treated for Diabetes (sugar)? ☐ YES ☐ NO

39. Been treated for Hypertension (high blood pressure)? ☐ YES ☐ NO

40. Been treated for Respiratory conditions (Emphysema, Bronchitis, Pneumonia, Asthma, Cystic Fibrosis etc.) ☐ YES ☐ NO

41. Had an organ transplant? ☐ YES ☐ NO

42. Had Major Surgery (any surgery in which you were put under general anesthesia and given respiratory assistance)? ☐ YES ☐ NO

43. Are you, or any of the eligible dependents, currently on medications? ☐ YES ☐ NO

44. Currently pregnant? ☐ YES ☐ NO
If "YES", please specify number of weeks gestation:

Has any approved insurer within the last (12) twelve months:

45 Declined a Health Insurance application for you, or any eligible dependent listed? ☐ YES ☐ NO

46. Required an increased premium or imposed special conditions on you, or any eligible dependent listed? ☐ YES ☐ NO

47. Cancelled or refused to renew an existing health insurance policy for you or any eligible dependent listed? ☐ YES ☐ NO

SECTION D(b): ANSWER DETAILS

If any of questions 33 through 47 was answered YES, please provide details below. Attach a separate page if needed.

Q No:	Name of Patient:	Diagnosis Date:	Treatment	Name and Address of Medical Provider

SECTION D: DECLARATION

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as of this date. I hereby authorize any medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to CINICO. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred within 24 months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and cancellation of coverage. I understand and agree that coverage shall not become effective until accepted by CINICO. I understand that any changes in my health status after submission of application and prior to the approval of coverage must be reported to CINICO. I hereby declare that I have read and understand the "Policy Rules and Eligibility Conditions" applicable to this Insurance policy.

Signature of Applicant:

Date:

Signature of Eligible Dependant: (18yrs or older)

THIS APPLICATION WILL BE VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE.

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION ON THIS MAY CAUSE YOUR APPLICATION AS WELL AS YOUR INSURANCE COVERAGE TO BE DEEMED NULL AND VOID.