Member Card Registration Form

(Please PRINT when filling out this form carefully and completely.)
If Indigent complete section 1-10 and 20 only)

MEMBER DETAILS

1. Last Name: First Name: Middle Name:

2. Date of Birth: 3. Gender: ☐ Male ☐ Female

4. Physical Address: District:

PO Box No: Postal Code:

5. Email Address:

6. Home No: 7. Work No: 8. Mobile No:

9. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

10. Employer or Government Department Name (if applicable):

11. Employer Contact No:

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12. Next of Kin:

Full Name: Contact No: PO Box No:

CINICO Cayman Islands National Insurance Company | T +1 345 949 8101 | F +1 345 949 8226 | www.cinico.ky
Maiden Place, 3rd Floor 227 Elgin Ave, P.O. Box 10112,
Grand Cayman KY1-1001

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DEPENDANTS

Identify Dependents by completing items 13 through 17 (continue on a seperate sheet if required).
Only dependents listed below will be covered. (Omit this section if dependent coverage is NOT desired.)
***If child is aged 18 and less than 23, attach full time student information.**

13.. Full Name(s) of Dependants	14. Relationship (Spouse/Child)	15. Gender	16. Birth Date	17. Other Insurance
a)				☐ Yes ☐ No
b)				☐ Yes ☐ No
c)				☐ Yes ☐ No
d)				☐ Yes ☐ No
e)				☐ Yes ☐ No

18. Spouse's Employer and Complete Address:

19. Dependant Health Plan Provider Information

Full Name(s) of Dependants	Insurance Company Details	Policy and ID No.	Coverage Type	Effective Date

SIGNATURE

20. Name: Signature: Date: