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Individual Health Application

Bermuda Life Insurance Company Limited

Essential Plan ☐ Vital Plan ☐ Classic Plan ☐
Classic Plan with Dental & Vision ☐

A: Applicant Information *Please complete a separate form for each Applicant*

Applicant Last Name: ____________________ First Name: _____________ Initial:___ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ **Sex** M ☐ F ☐

Occupation (state day to day activities): ______________________________________ Nationality: ______________________________

Date of Birth: ____/____/____ Height: _______ Weight: _______ Marital Status: Single ☐ Married ☐ Separated/Divorced ☐ Widowed ☐
M D Y ft & in lbs

Home Address Home Tel. Work Tel.

If the Applicant is not the intended policyholder, please state relationship to the intended policyholder:

B: Statement of Health *Please answer every question. If any question is answered 'yes' also complete Section D.*
(Use separate forms for dependents.)

		Yes	No
1.	Have you ever had, sought advice for, or been told you have any:		
a)	cardiovascular disease or disorder such as stroke, angina, heart disease, high blood pressure, circulatory problems, chest pains, or varicose veins?......................	☐	☐
b)	respiratory disease or disorder such as lung disease, chronic cough, shortness of breath, asthma, tuberculosis, , pleurisy or bronchitis?..............................	☐	☐
c)	urinary, kidney, prostate, bladder disease or disorder or any disease or disorder of the reproductive system?……	☐	☐
d)	gastrointestinal disease or disorder such as ulcer, colitis, diarrhoea, digestive problems, hepatitis or liver disorder?	☐	☐
e)	neurological disease or disorder such as dizzy spells, epilepsy, paralysis, recurrent headaches, fits or seizures?..	☐	☐
f)	arthritis, rheumatism, gout, neck or back problems, disc disease, joint or bone disorders including sprains and strains, chronic fatigue syndrome and fibromyalgia?……	☐	☐
g)	diabetes, sugar in urine or thyroid disorder?………	☐	☐
h)	any difficulties with eyes, ears, nose or throat?………….	☐	☐
i)	H.I.V., A.I.D.S. or A.I.D.S. related conditions?.......... …	☐	☐
j)	treatment for drug use, stress, anxiety, depression or any other mental or psychiatric problems?……………………	☐	☐
k)	disease or disorder of the skin?……………………………	☐	☐
l)	disease or disorder of the blood including anaemia or haemophilia? ………………………………………………...	☐	☐
m)	cancer, tumour or any other growth or malignancy? …….	☐	☐
n)	enlargement of lymph nodes, glands, unusual or persistent skin lesions or unexplained infections?………………………	☐	☐
o)	illness, personal injury, birth defect, congenital defect, disease or disorder not mentioned above?…………………	☐	☐
2.	Have you had an increase or decrease in weight of 10 lbs or more in the past 12 months? If yes, then indicate details in Section D ……………………………………………………	☐	☐
3.	During the last 10 years have you:		
a)	had or been advised to have surgical procedures, special examinations or laboratory tests, blood transfusions, or been treated in a hospital?……………………………………	☐	☐
b)	used cocaine, heroin or other narcotics, marijuana, LSD, or amphetamines, except as prescribed by a physician?…….	☐	☐
4.	Are you planning to have surgery?…………………………..	☐	☐
5.	In the past 5 years, have you been absent from work for more than 5 consecutive days, due to illness or injury?.......	☐	☐
6.	Are you currently receiving medical treatment by diet, medicine or other means?……………………………..…….	☐	☐
7.	Do you engage, or have you ever engaged, or do you have any intention or prospect of engaging in scuba diving, sky diving, motor vehicle, motorcycle or boat racing, or flying other than a passenger on a regularly scheduled flight?......	☐	☐
8.	Have you ever been refused health insurance, or had it offered on special terms?……………………………………… Rated ☐ Declined ☐	☐	☐
9.	Have you any intention or prospect of residing or traveling outside Bermuda other than on a vacation?…………………	☐	☐
10	Are you pregnant?……………………………………………...	☐	☐

Name of regular attending Physician: ____________________ Address: ______________________________

Date of last visit: ____________________ Reason for visit: ______________________________

C: Coverage Details

If you or your spouse have any other health insurance policy, please complete the following information:

Name of Insured: ____________________________ Policy date: _____ /_____/ _____ Policy Number: ______________________
M D Y

Type of Insurance: __________________________ Name of Insurance Company: ____

If you or your dependents are not presently insured, what is the reason for applying for health insurance at this time?

Individual Class applied for: Public Ward ☐ Semi-Private ☐

D: Additional Details

(Complete this section for any questions answered 'yes' in Section B. If additional space is required, please attach a separate sheet, and date and sign each sheet.)

Question	**Date of Occurrence**	**Description** (e.g., treatment received, name and address of physician or hospital, etc)

E: Special Notice

Any person, who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits a declaration or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

F: Declaration

I certify that the statements on both sides of this form and on any attached sheet, are true and complete to the best of my knowledge and belief, and that no material information has been withheld or suppressed. I agree that this document and all its contents will form part of my enrolment for the insurance applied for. This information may be used by the Insurer to decide whether I am eligible for coverage. I understand that payment of the first month's premium and administration fee must accompany this Application. I understand that coverage will begin subject to satisfactory completion of the underwriting process. In the event the application is declined, the first month's premium deposit will be refunded. I agree that if I have made any willfully false statement or material omission in this application the insurer shall be entitled to cancel this policy and the insurer will be under no obligation to pay any benefit for which evidence of insurability was required.

I authorise the Insurer to exchange such information as may be required for underwriting, administration and claims payment, with any person or organisation which has relevant personal information about me (including other insurers, medical practitioners and institutions), and persons who perform insurance functions or medical services for the Insurer. I understand that the Insurer will not be responsible for the payment of any fee charged for providing such information. A photocopy or facsimile of this authorisation is as valid as the original.

Applicant's Signature (Parent or Guardian if child):____ Date: ____ /____/____
M D Y

Would you like to receive your Individual Health Policy and monthly bills by e-mail? Yes ☐ No ☐
If yes, please provide e-mail address ____

For Company Use Only

Effective date of Health Plan: Premium Received $ ☐ Cash ☐ Cheque

Premium Calculation: Applicant	Spouse	Child	Total	Admin. Fee

Received by:	Date (month/day/year)	Underwritten by:	Date (month/day/year)

Remarks