Generali Worldwide

Health Insurance Application Form

Please complete all sections in BLOCK CAPITALS or tick the boxes, where appropriate.

1. **Employer:**
2. **Employee's Name:**
3. **Employer Group Number:**
4. **Date of Birth:** M M D D Y Y
5. **Sex:** Male ☐ Female ☐
6. **Height:**
7. **Weight:**
8. **Marital Status:**
9. **National Insurance Number:**
10. **Email Address:**
11. **Telephone:**
    - Work:
    - Home:
    - Mobile:
12. **Employee's date of hire:** M M D D Y Y
13. **Insurance Effective Date:** M M D D Y Y
14. **Plan coverage requested:**   **Life Amount:**   **Annual Salary:**

PLEASE COMPLETE THE FOLLOWING DETAILS FOR ANY FURTHER APPLICANTS (DEPENDANTS) ELIGIBLE FOR COVER

15. Name	Sex (M/F)	Relation	Date of Birth	Height	Weight
a)			M M D D Y Y		
b)			M M D D Y Y		
c)			M M D D Y Y		
d)			M M D D Y Y		
e)			M M D D Y Y		

16. **Please answer the following questions and provide details where requested if covering dependants:**

If any dependant aged 19 or older requires coverage, are they attending school full-time? Yes ☐ No ☐
If YES, please attach proof of student status.

Is any dependant of the applicant actively employed? Yes ☐ No ☐
If YES, give name of the employer and other insurance details:

Is any applicant covered under another health insurance including free care at government facilities? Yes ☐ No ☐
If YES, give name of other insurance company and the name of policyholder, ID Number & Effective Date:

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17. Physician's name, address and telephone number:

Name:

Address:

Telephone:

Answer the following questions for ALL applicants and give complete details for any 'YES' answers using the space provided under Question 22.

18. Previous Insurance

Has any applicant ever been denied life, disability, medical, dental or any group coverage, or offered coverage with an exclusion for a specific condition? Yes ☐ No ☐

If YES, please list applicant name and details:

Have you ever applied for coverage with Generali Worldwide? Yes ☐ No ☐

If YES, Previous Generali Worldwide ID:

Has the applicant been insured in the past 12 months in the Bahamas by an approved insurer with no break in cover for more than 60 days? Yes ☐ No ☐

If YES, please provide name of Insurer:

19. Statement of General Health:

a) Is any applicant pregnant? If YES, expected delivery date: M M D D Y Y Yes ☐ No ☐

b) Are any medical/ surgical or dental procedures (including x-ray, lab or other testing) recommended, scheduled and/or contemplated for any applicant? Yes ☐ No ☐

c) Is any applicant currently taking prescribed medications (including birth control) for any condition? Yes ☐ No ☐

If YES list individual(s) name, medication, dosage, duration and diagnosis.

d) Does any applicant use tobacco products (including cigarettes, cigars, pipes etc or chewing tobacco?) Yes ☐ No ☐

Indicate which applicant: packs per day: and number of years used:

e) Including work permit exams and annual physicals, within the past 5 years has any applicant been examined by, consulted with, or received medical treatment from any doctor, dentist, or other medical provider? Yes ☐ No ☐

f) Within the past 5 years, has any applicant been confined (stayed overnight) in any hospital, clinic, sanatorium or other treatment facility? Yes ☐ No ☐

20. Is there any known or likely need for any applicant to seek advice, treatment or investigations from a health care professional? (This includes symptoms you are aware of, even if undiagnosed or untreated) Yes ☐ No ☐

I certify that the above information is correct - Authorized Employer Representative Signature:

Name:

Date: M M D D Y Y

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21. Within the past 5 years, has ANY applicant had any disease / impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for any of the medical conditions below?

For all 'YES' answers provide complete details regarding the condition under Q22.

	YES	NO		YES	NO
AIDS / ARC / HIV	☐	☐	Gastrointestinal / digestive disorder: stomach, intestines, bowel	☐	☐
Alcohol dependency or drug / substance abuse	☐	☐	Genital organs / tract, reproductive system, prostate disorder or infertility	☐	☐
Anaemia or any other blood disorder	☐	☐	Glandular disorder	☐	☐
Anxiety, depression or any mental or nervous disorder	☐	☐	Gout, thyroid disorder or any other endocrine or metabolic disorder	☐	☐
Arthritis, rheumatism or any disorder of any joints, bones, muscles or spine / back / neck (including any fractures)	☐	☐	Hernia	☐	☐
Asthma, bronchitis, pleurisy, pneumonia, tuberculosis or any other disorder of the lungs or respiratory system	☐	☐	Immune System Disorder	☐	☐
Blood pressure/ hypertension, raised cholesterol, blood clots, vascular disease or any other circulatory disorder	☐	☐	Injury, operation, physical defect or deformity	☐	☐
Cancer, tumour, growth or cyst	☐	☐	Kidney, bladder, urinary tract or urinary abnormality	☐	☐
Cerebrovascular disorder e.g. stroke, transient ischaemic attack (TIA), brain haemorrhage	☐	☐	LIver, gall-bladder, pancreas or spleen disorder	☐	☐
Chest pains, palpitations, heart murmur, angina, heart attack, or any other heart disorder	☐	☐	Paralysis or any disorder of the neurological / nervous system	☐	☐
Dental/ Gum Disease	☐	☐	Rheumatic Fever	☐	☐
Diabetes	☐	☐	Skin disease or disorder	☐	☐
Ears, eyes, nose or throat disease or disorder	☐	☐	Surgical Operation	☐	☐
Epilepsy, convulsions, seizures, fits	☐	☐	**Any other disorder or condition not listed above**	☐	☐

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22. **If the answer to any of the above is 'YES' please provide the item number and answer the following questions (please use additional paper if necessary).**

Name	Item #	Symptom/ Condition	Doctor's Name	Dates MM/DD/YY	Treatment received	Status stable/ ongoing/ full recovery

23. **Life Insurance (complete only if Life Insurance benefits apply)**

Life / AD&D Beneficiary Name(s) (First, Middle, Last)	Beneficiary Relationship	Percentage
1.		
2.		

Have any of your natural grandparents, parents, brothers or sisters suffered from or died from heart disease, stroke, high blood pressure, diabetes, kidney disease or cancer before they reached the age of 65, multiple sclerosis, Huntington's diseases or from any other hereditary illness? Yes ☐ No ☐

If YES, please state the relationship, condition (if cancer please specify site), age diagnosed and age at death (if applicable):

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Certification: I hereby request the group insurance coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. I certify these answers and statements are complete and true to the best of my knowledge and belief. ***I will inform Generali Worldwide of any changes in my or my family's health or of any change to the information provided which take place between the time the form is completed and the time coverage becomes effective.*** I agree that this document shall form a part of my request for group coverage.

Acknowledgement: I understand that, to the extent permitted by statute or policy, false statements or misrepresentations in my application or addendums may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my employer's Plan including any pre-existing condition limitations, employee actively at work and dependant health condition requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical, or hospital service and prepaid health plans, and employers: you are authorized to provide Generali Worldwide and its affiliates, including any reinsurer, any and all information requested concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ ARC/ HIV) provided to me or any members of my family for whom coverage has been requested. This information may be used for the purpose of determining eligibility for coverage and in the adjudication of future claims. I agree that a copy of this authorization is as valid as the original. FRAUD WARNING NOTICE:
Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a Health Insurance Application Form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee's Signature: (Employee must sign at all times)

Date: M M D D Y Y

Spouse's Signature: (Spouse must sign when spouse coverage is requested)

Date: M M D D Y Y

This completed and signed form may be mailed to: Generali Worldwide, P.O. Box Ap-59217 Slot 2052, Nassau, Bahamas or faxed to +1 242 328 5972.

Declaration of Continued Good Health (to be completed if cover is not approved within 90 days from the date original application is signed)

Since the date the original Health Insurance Application was signed, have/do any applicants:

1. Experienced any symptoms of any new health problem or condition? Yes ☐ No ☐
2. Received any advice, treatment or investigations from any health professional or hospital facility? Yes ☐ No ☐
3. Intend to seek advice, treatment or investigations from any health professional or hospital facility in future? Yes ☐ No ☐

If the answer is yes to any of the above, please provide applicant name and full details on Page 1.
It is understood and agreed that the above statements and answers are true and complete to the best of my knowledge. It is understood that additional information or examination by a physician may be required.

Employee's Signature: (Employee must sign at all times)

Date: M M D D Y Y

Office: Generali Worldwide, 2nd Floor, Campbell Maritime Centre, West Bay Street, Nassau, Bahamas.
Mailing address: Generali Worldwide, P.O. Box AP-59217, Slot 2052, Nassau, Bahamas.
Licensed by the Insurance Commission of the Bahamas to carry on long-term insurance business in the Commonwealth of the Bahamas.
Incorporated in Guernsey under Company Registration No. 27151.
T +1 242 328 6330 F +1 242 328 5972
salesbahamas@generali-worldwide.com

Generali Worldwide is a trading name of Utmost Worldwide Limited
Registered Head Office address: Utmost Worldwide Limited, Utmost House, Hirzel Street, St Peter Port, Guernsey, Channel Islands GY1 4PA.
Regulated in Guernsey as a licensed insurer by the Guernsey Financial Services Commission under the Insurance Business (Bailiwick of Guernsey) Law, 2002 (as amended).

Incorporated in Guernsey under Company Registration No. 27151.

generali-healthcare.com

Websites may make reference to products that are not authorised or regulated and/or are not available for offering to planholders in certain jurisdictions.

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