Generali Worldwide

Group Health Insurance – Health Insurance Application Form

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

A completed Health Insurance Application is required for all new applicants for coverage, for any previous member who has had a gap in coverage, and for any applicants who are requesting an increase in or significant change to existing coverage. In addition to this form, a medical examination is required for any applicant(s) age 60 and over, and any applicants requesting Life Insurance in excess of $100,000.

Employer Instructions

Employers should complete Section A. After you have completed Section A, give the form to your employee to complete Section B. They may either return this directly to Generali Worldwide's representative in Cayman (in person, via fax or email), or return to you to provide to Generali Worldwide on their behalf.

Employee Instructions

Please confirm that your details in Section A are correct, then complete Section B. Please be sure that all questions are completely answered, providing dates and details as appropriate. Be certain that only the names of individuals requesting coverage (you and any dependants) are listed. Sign and return the completed form to Generali Worldwide or your Human Resources Representative. If you are requesting coverage for your spouse they must sign the form as well. Please note: if you are required to obtain a medical or other exam to satisfy our requirements of insurability you will be responsible for the cost.

SECTION A – To be completed by the employer

Please complete the following section. If you are not an existing employer, please write N/A in #1.

1. Employer Group Number:
2. Employer/ Company Name:
3. Employer mailing address:
4. Employer physical address (if different from mailing address):
5. Employer phone number: Fax number:
   E-mail address:
6. Employee Name:
7. Employee date of hire: M M D D Y Y (MM/DD/YY)
8. Employee job title:
9. Requested Effective Date: M M D D Y Y (MM/DD/YY)

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10. If employee is currently covered by Generali Worldwide, what is their member identification # or the company name?

11. Please indicate if you are requesting: Global ☐ WorldChoice ☐ CaymanChoice ☐ ClearChoice ☐

Deductible amount chosen:

12. Requested group life amount: $10,000 ☐ $50,000 ☐ 2 X salary to $100,000 (list salary below) ☐

Annual Salary: U.S. Dollars $ per year and C.I. Dollars $ per year

I certify that the above information is correct

Authorized Employer Representative Signature: Date: M M D D Y Y (MM/DD/YY)

SECTION B – To be completed by the employee

Please complete the following section. Please type or print clearly in ink.

1. Employee Contact Information:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

2. Have you ever applied for coverage with Generali Worldwide? Yes ☐ No ☐ When? M M D D Y Y (MM/DD/YY)

3. Has the employee been insured for the past 12 months in Cayman by an approved insurer with no breaks in coverage for more than 3 months?

Yes ☐ No ☐ Name of insurer:

If yes, provide the starting date: M M D D Y Y and the ending date: M M D D Y Y (MM/DD/YY)

4. Number of sick days in the last full calendar year:

5. Location of Dependants:

6. Personal Details:

	Name(s) of person(s) to be covered	Previous Generali Worldwide ID # (if any)	Birth Date mm/dd/yy	Citizenship	Gender (male or female)	Height (indicate ft/ inches)	Weight (indicate pounds)
a) employee							
b) spouse							
c) child							
d) child							
e) child							
f) child							

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7. Please answer the following questions and provide details where requested if covering children:

If any dependant, age 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 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, name of other Insurance Company: and the

Name of Policyholder: ID Number: & Effective Date: (MM/DD/YY) M M D D Y Y

Do all dependant children requiring coverage live in your household?

If No, provide contact details:

8. Statement of General Health: Answer the following questions for ALL applicants.
Give complete details for "Yes" answers using the space provided under #12.

a. Is any applicant pregnant? Yes ☐ No ☐ If Yes, expected delivery date: M M D D Y Y (MM/DD/YY)

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 taking prescribed medications (including birth control) for any condition or has any medication/ treatment been prescribed during the last 6 months? Yes ☐ No ☐

If Yes, list individual(s) name: Medication:

Dosage: Duration: Diagnosis:

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

Indicate which applicant: Packs per day: # of years used:

e. Including work permit exams, within 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 hospital, clinic, sanatorium or other treatment facility? Yes ☐ No ☐

GW (UW) HC Cay GHI Health Ins App

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

If Yes, list applicant name and details:

9. Has ANY applicant had any disease or impairment of or suffered any symptoms or required any medication, treatment or hospital consultation(s) for the medical conditions below? Please check YES if applicant has any history of the following problems. Please check NONE if no history of any of the listed problems exists. For all YES answers please provide complete details regarding the condition, etc under #12.

History of Prior/ Current Medical Conditions None ☐

	YES		YES		YES
AIDS/ ARC/ HIV	☐	Cholesterol	☐	Mental/ Nervous Disorder	☐
Alcohol dependency or drug/ substance abuse	☐	Cystic Fibrosis	☐	Neurological/ Nervous System	☐
Anaemia or any other blood disorder	☐	Dental/ Gum Disease	☐	Paralysis	☐
Arthritis, or any disorder of any muscles, bones or joints	☐	Diabetes	☐	Prostate	☐
Asthma, bronchitis or any other respiratory disorder	☐	Ears, eyes, nose or throat	☐	Rheumatic Fever	☐
Back/ Spine/ Neck	☐	Epilepsy, convulsions, seizures, fits	☐	Reproductive Disorder or Infertility	☐
Blood Pressure/ Hypertension	☐	Gastrointestinal (stomach/ intestines)	☐	Sexually Transmitted Disease	☐
Blood Vessels/ Clots/ Circulatory system	☐	Gout	☐	Skin	☐
Bones (including fractures)	☐	Hernia	☐	Sleep Disorder	☐
Brain/ Head	☐	Immune System Disorder	☐	Stroke	☐
Cancer, tumour, growth or cyst	☐	Injury, operation, physical defect or deformity	☐	Surgical Operation	☐
Carpal Tunnel Syndrome	☐	Kidney/ Bladder/ Urinary Tract	☐	Thyroid or Endocrine System	☐
Cerebrovascular Disease/ Disorder or Stroke	☐	Liver, gall-bladder, pancreas or spleen	☐	Ulcer	☐
Chest pains, palpitations, heart murmur, angina, heart attack, any other heart disorder	☐	Lungs/ Breathing	☐	Urinary Abnormality	☐
				Other medical impairment not listed	☐

10. Is there an oral/ dental condition(s) needing treatment (other than normal cleaning & routine exams) by any applicant requesting coverage? Yes ☐ No ☐

If Yes, give full details under #12 below (e.g. number of fillings, crowns, extractions, missing teeth, surgery, orthodontic treatment, etc).

11. Does any individual(s) have a known physical impairment(s) or ill health not mentioned in Sections 9 & 10? If Yes, give full details under #12. Yes ☐ No ☐

12. Use this space to provide details for your answers and medical issues/ visits identified in numbers 8 – 11.
If you need more space, provide full details on a separate sheet and return it with your application.

Applicant Name	What was wrong?	Dates mm/dd/yy	What was done to help?	Doctor's Name	Status (e.g. ongoing or fully recovered?)

If the visits above were routine in nature and no follow up is required, please check here: ☐

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

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13. 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 affiliates information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ ARC/ HIV) provided 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 history questionnaire or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employee Signature (Employee must sign at all times): ________ Date: M M D D Y Y (MM/DD/YY)

Spouse's Signature (Spouse must sign when spouse coverage is requested): ________ Date: M M D D Y Y (MM/DD/YY)

This completed and signed form may be returned to: Generali Worldwide, PO Box 10281, Grand Cayman, KY1-1003 Cayman Islands. Fax +1 345 943 7288 Email caymanservicing@generali-healthcare.com

SECTION C – To be completed by Generali Worldwide.

Effective Date: ________ / 01 / ________

By: ________ Date: M M D D Y Y (MM/DD/YY)

Office: Generali Worldwide, Suite 14, Grand Pavilion Commercial Centre, 802 West Bay Road, Grand Cayman, KY1-1003
Mailing address: Generali Worldwide, PO Box 10281, Grand Cayman, KY1-1003 Cayman Islands.
Regulated in the Cayman Islands as a licensed insurer by the Cayman Islands Monetary Authority.
Incorporated in Guernsey under Company Registration No. 27151.
Tel. +1 345 940 2000 Fax +1 345 943 7288 Email caymanservicing@generali-healthcare.com
generali-healthcare.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).

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GW (UW) HC Cay GHI Health Ins App 02'21