Group Health Insurance Application Form

PLEASE COMPLETE THIS FORM USING BLOCK CAPITALS

A completed Health Insurance Application Form 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.

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 Insurance Company Ltd, or return to you to provide to Generali Worldwide Insurance Company Ltd on their behalf.

EMPLOYEE INSTRUCTIONS

Please confirm that your details in Section A are correct. 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 Insurance Company Ltd or your Human Resources Representative to forward on your behalf. 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 Q1.

1. Employer Group Number:

2. Employer/Company Name:

3. Employee's Name:

4. Employee's date of hire: D D M M Y Y 5. Insurance Effective Date: D D M M Y Y

6. Employee's job title:

7. Plan coverage requested: Life Amount: Annual Salary:

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

Name: Date: D D M M Y Y

SECTION B - To be completed by the employee

PLEASE COMPLETE THE FOLLOWING SECTION. PLEASE TYPE OR PRINT CLEARLY IN INK.

1. Marital Status: Identification Number:

2. Employee Contact Information:

Home phone: Work phone:

Cell phone: email address:

3. Have you ever applied for coverage with Generali? Yes No When:

4. Has the employee been insured for the past 12 months by an approved insurer with no breaks in coverage for more than 60 days? YES NO

Name of Insurer:

5. Personal Details

New Enrollment ☐ Adding Dependant ☐

	Name(s) of person(s) to be covered	Previous Generali ID (if any)	Birth Date dd/mm/yyyy	Birth Place	Gender (M/F)	Height (ft/inches)	Weight (pounds)
a) employee							
b) spouse							
c) child							
d) child							
e) child							
f) child							

6. 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

Do all dependant children requiring coverage live in your household? If No, provide contact details YES ☐ NO ☐

7. Statement of General Health:
Answer the following questions for ALL applicants. Give complete details for "Yes" answers using the space provided under Q12.

a. Is any applicant pregnant? If Yes, expected delivery date. YES ☐ NO ☐ D D M M Y Y

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

YES ☐ NO ☐

d. Does any applicant use tobacco products (including cigarettes, cigars, pipes etc or chewing tobacco?)
Indicate which applicant, number of packs per day and number of years used

YES ☐ NO ☐

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 ☐

g. Has any applicant ever been denied life, disability, medical, dental or any group coverage, or offered coverage with an exclusion for a specific condition? If Yes, list applicant name and details: YES ☐ NO ☐

8. 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 tick 'YES' if applicant has any history of the following problems. Please tick 'NONE' if no history of any of the listed problems exists. For all 'YES' answers please provide complete details regarding the condition under Q12.

History of Prior/Current Medical Conditions NONE ☐

check if yes

- ☐ AIDS/ARC/HIV
- ☐ Alcohol dependency or drug / substance abuse
- ☐ Anaemia or any other blood disorder
- ☐ Anxiety, depression or any mental or nervous disorder
- ☐ Arthritis, rheumatism or any disorder of any joints, bones, muscles or spine/back/neck (including any fractures)
- ☐ Asthma, bronchitis, pleurisy, pneumonia, tuberculosis or any other disorder of the lungs or respiratory system
- ☐ Blood pressure/hypertension,raised cholesterol, blood clots, vascular disease or any other circulatory disorder
- ☐ Cancer, tumour, growth or cyst
- ☐ Cerebrovascular disorder e.g. stroke, transient ischaemic attack (TIA), brain haemorrhage
- ☐ Chest pains, palpitations, heart murmur, angina, heart attack, or any other heart disorder
- ☐ Dental / Gum Disease
- ☐ Diabetes
- ☐ Ears, eyes, nose or throat disease or disorder

check if yes

- ☐ Epilepsy, convulsions, seizures, fits
- ☐ Gastrointestinal/digestive disorder: stomach, intestines, bowel
- ☐ Genital organs/tract, reproductive system, prostate disorder or infertility
- ☐ Glandular disorder
- ☐ Gout, thyroid disorder or any other endocrine or metabolic disorder
- ☐ Hernia
- ☐ Immune System Disorder
- ☐ Injury, operation, physical defect or deformity
- ☐ Kidney, bladder, urinary tract or urinary abnormality
- ☐ Liver, gall-bladder, pancreas or spleen disorder
- ☐ Paralysis or any disorder of the neurological/nervous system
- ☐ Rheumatic Fever
- ☐ Skin disease or disorder
- ☐ Surgical Operation

9. Does any applicant have any known medical condition(s) or physical impairment(s) not mentioned in Section 8? If Yes, give full details under Q12. YES ☐ NO ☐

10. Is there any 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 Q12 (e.g. number of fillings, crowns, extractions, missing teeth, surgery, orthodontic treatment, etc)

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11. Name, address and telephone number of your personal/family physicians.

NAME:

ADDRESS:

TELEPHONE:

12. Use this space to provide details for your answers and medical issues/visits identified in numbers 7 - 10.
If you need more space, provide full details on a separate sheet and return it with your application.

REF.	Applicant Name	Exam/Visit/ Diagnosis	Treatment	Doctor's Name	Dates	Results

If the visits above were routine in nature, with no adverse findings, and no treatment or follow-up is required tick here ☐

13. Life Insurance (Complete only if Life Insurance benefits apply.)

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

Certification: I hereby request the group insurance coverage for which I am or may become eligible and authorise 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 Insurance Company Ltd 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. Authorisation: 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 authorised to provide Generali Worldwide Insurance Company Ltd 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 authorisation 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: D D M M Y Y

SPOUSE'S SIGNATURE (must sign spouse coverage is requested)

DATE: D D M M Y Y

This completed and signed form may be mailed to:
Generali Worldwide Insurance Company Ltd, P.O. Box Ap-59217 Slot 2002,
Sandringham House, 83 Shirley Street, Nassau, Bahamas or faxed to +1 242 328 5972