CG | BRITCAY

REQUEST FOR PROPOSAL

Health Insurance

PART 1 APPLICANT DETAILS

Company Name _____

Mailing Address _____

Contact Person _____ E.Mail _____

Phone No. _____ Fax No. _____

Total Number of Employees _____ Total Number of Dependents _____

Type of Business _____ Effective Date (DD/MM/YY) _____

Agent _____ Broker _____

Previous Medical Client? ☐Yes ☐No If Yes, previous Policy No._____ Cancellation Date (DD/MM/YY)_____

PART 2 TYPE OF COVER REQUESTED

☐ New Business ☐ Change Existing Business: Policy _____

PART 3 DETAILS OF COVER REQUESTED

☐ **Medical Plan Benefit** ☐ Premier Health ☐ Provident Plan ☐ SHIC Enhanced ☐ 125 ☐ 250 ☐ SHIC (Basic)

☐ **Dental Plan Benefit** ☐ Comprehensive ☐ Basic

☐ **Vision Plan Benefit** ☐ Comprehensive ☐ Basic

☐ **Life Benefit** ☐ Flat Amount of $ _____ OR ☐ Multiple of Salary = ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ **Supplemental Life Benefit** ☐ Flat Amount of $ _____

☐ **Dependent Life Benefit** ☐ Flat Amount Spouse $ _____ ☐ Flat Amount Child $ _____

☐ **Accidental Death & Dismemberment** ☐ Flat Amount $ _____ OR ☐ Multiple of Salary = ☐ 1 ☐ 2 ☐ 3 ☐ 4

☐ **Short Term Disability Benefit** ☐ 50% ☐ 60% ☐ 66.66% ☐ 70% of Weekly Salary to Max Amount $ _____

☐ **Long Term Disability Benefit** ☐ 50% ☐ 60% ☐ 66.66% ☐ 70% of Weekly Salary to Max Amount $ _____

Waiting Period: ☐ 90 days ☐ 180 days

Duration of Benefits: ☐ 2 yrs ☐ 5 yrs ☐ to age 65 ☐ RBD

☐ **Critical Illness Benefit**** Max Benefit Options: ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ **Supplemental Accident Benefit****

**These Optional benefits will be: ☐ Voluntary (Employee funded) OR ☐ Non-Voluntary (Company funded)

PART 4 MEDICAL PROFILE

The following questions must be answered to the best of your knowledge for all employees and their dependents to be insured (proprietors, partners, corporate officers, employees, spouses, and dependent children.) The information in this Section is designed to assist in evaluating your Group. It is therefore essential that the information provided be complete and true to the best of your knowledge.

Place answer Yes or No giving details on questions to which you answer Yes in the space provided on the following pages.

A. Has anyone been treated for, or shown symptoms of illness, or had surgery in the past five years? (e.g. Cancer, Juvenile diabetes, Cardiovascular Disease, AIDS, Substance Abuse, Renal Disease, Mental Illness). ☐ Yes ☐ No

B. Has anyone undergone open-heart surgery or received cardiac testing at anytime in the past? (e.g. Cardiac Catherisation, Angioplasty, By-pass Graft, Pacemaker, Valve Replacement.) ☐ Yes ☐ No

C. Has anyone had a claim of $20,000 or more in the past 12 months? (Include copy of detailed claims reports if available.) ☐ Yes ☐ No

D. Is anyone apt to have a continuing claim for a mental or physical disorder? ☐ Yes ☐ No

E. Has anyone been advised to have surgery or diagnostic testing in the last six months or anticipate hospitalization for any other reason? ☐ Yes ☐ No

F. Has any employee missed 10+ consecutive days of work in the past 12 months due to an illness or injury? ☐ Yes ☐ No

G. Are there any spouses or dependents who are confined at home, incapacitated or confined in a hospital or treatment facility? ☐ Yes ☐ No

H. Are there any employees who are not actively at work performing their duties full time, due to illness or injury? ☐ Yes ☐ No

I. Are there any employees or dependent now not insured who have been declined for life or medical cover? ☐ Yes ☐ No

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PART 5 MEDICAL PROFILE DETAILS

Please complete the following section if you have answered 'Yes' to any of the questions on the previous page.

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: ______________________ Patient Age: ______ Question Ref. ______

Diagnosis: ______________________

Treatment: ______________________

Prognosis: ______________________

Does the patient currently have insurance? ☐ Yes ☐ No

Health Insurance

Patient Name: _____ Patient Age: _____ Question Ref. _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: _____ Patient Age: _____ Question Ref. _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? ☐ Yes ☐ No

Patient Name: _____ Patient Age: _____ Question Ref. _____

Diagnosis: _____

Treatment: _____

Prognosis: _____

Does the patient currently have insurance? ☐ Yes ☐ No

PART 6 COMMENTS/QUESTIONS

British Caymanian Insurance Agencies Limited BritCay House, 236 Eastern Ave, George Town, Grand Cayman, Cayman Islands
PO Box 74, Grand Cayman, KY1-1102 Cayman Islands | Tel 345 949 8699 | Fax 345 945 0658 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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Health Insurance

PART 7 GROUP CENSUS

No.	Gender	Date of Birth (DD/MM/YY)	Dependents*	Occupation	Annual Salary
1	☐M ☐F				
2	☐M ☐F				
3	☐M ☐F				
4	☐M ☐F				
5	☐M ☐F				
6	☐M ☐F				
7	☐M ☐F				
8	☐M ☐F				
9	☐M ☐F				
10	☐M ☐F				
11	☐M ☐F				
12	☐M ☐F				
13	☐M ☐F				
14	☐M ☐F				
15	☐M ☐F				
16	☐M ☐F				
17	☐M ☐F				
18	☐M ☐F				
19	☐M ☐F				
20	☐M ☐F				
21	☐M ☐F				
22	☐M ☐F				
23	☐M ☐F				
24	☐M ☐F				
25	☐M ☐F				
26	☐M ☐F				
27	☐M ☐F				
28	☐M ☐F				
29	☐M ☐F				
30	☐M ☐F				
31	☐M ☐F				
32	☐M ☐F				

* E = Employee only
EE+SP = Employee and Spouse
EE+C = Employee and Child(ren)
F = Family