HEALTH INSURANCE **APPLICATION**

BAF Med**Safe** Secure Care Plus • **BAF** Med**Safe** Critical Care 500

☐ New Application ☐ Additional Dependents ☐ Change of Plan

Agent/Broker		Policy Number		Effective Date	

A. APPLICANT'S INFORMATION

First Name		M.I.		Last Name	
Address	Street			P.O. Box	
City				Island	
Telephone #s	Home			Mobile	
Email Address				Nationality	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower				

B. PRODUCT AND PLAN SELECTION

☐ MedSafe Critical Care 500	Plan 1 ☐	Plan 2 ☐	Plan 3 ☐	Plan 4 ☐	
Individual Deductible:	$2,000	3,500	5,000	10,000	
☐ MedSafe Secure Care Plus	Plan 1 ☐	Plan 2 ☐	Plan 3 ☐	Plan 4 ☐	
Individual Deductible:	$500	1,000	2,000	5,000	

C. LIFE INSURANCE BENEFICIARY INFORMATION

Main Insured	Beneficiary's Name		Relationship	
	Beneficiary's Address		Phone #	
Spouse	Beneficiary's Name		Relationship	
	Beneficiary's Address		Phone #	

D. APPLICANT'S & DEPENDENTS' INFORMATION

	Family Members' Names (List all family members) Last First Middle	Birth Date (DD/MM/YYYY)	Place of Birth & Nationality	Sex M F	Smoker Yes No	Height Ft : Ins	Weight in lbs
Applicant				☐ ☐	☐ ☐		
Spouse				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		
Child				☐ ☐	☐ ☐		

If this application includes children **between 19 & 24 years old,** are any of them a full-time student in a college or university? ☐ Yes ☐ No. If "Yes", please indicate the name of the college of university and provide a copy of a certificate or affidavit from the college or university as evidence of full-time student status.

E. EMPLOYMENT INFORMATION

	Applicant	Spouse
Occupation		
Employer's Name		
Nature of Business		

F. CURRENT/PRIOR COVERAGE INFORMATION

Do you have health insurance coverage with another company? ☐ Yes ☐ No If the answer is "Yes", please provide the Company name, product name, deductible value and Policy number in the space below:

F. CURRENT/PRIOR COVERAGE INFORMATION cont'd...

In respect of you, your spouse and any of your dependents, has any insurer within the last 3 years:

a) Declined an application for Health Insurance? ☐ Yes ☐ No

b) Required an increased premium or imposed special conditions? ☐ Yes ☐ No

c) Cancelled or refused to renew an existing health policy? ☐ Yes ☐ No

If the answer is Yes to any of the above? Please explain below:

d) Do you intend to keep your insurance coverage with the other company? ☐ Yes ☐ No

If the requested coverage is replacing an existing insurance policy, please attach a copy of the certificate and receipt of last payment.

e) Do you or any of your dependents have any existing policies with BAF? ☐ Yes ☐ No. If the answer is "Yes", please give the plan/product details below:

G. PAYMENT INFORMATION (payment must be submitted with the application)

Policy Type: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

	Premium Total	

Payment Methods:

☐ Salary Savings *(please see signed salary attached)*

☐ Pre-Authorized Cheques (PAC) *(please see signed PAC form attached)*

☐ Post-dated Cheques *(six months or more)*

☐ Cash Payments at BAF Office *(semi-annual premiums only)*

☐ Credit Card *(please see signed form with card information attached)*

H. AUTHORIZATION & SIGNATURE

I UNDERSTAND THAT HEALTH INSURANCE BENEFITS MAY BE LIMITED OR EXCLUDED FOR CONDITIONS FOR WHICH A FAMILY MEMBER (INCLUDING MYSELF) HAS RECEIVED ANY MEDICAL DIAGNOSIS OR TREATMENT OR TAKEN ANY MEDICATION OR WHERE DISTINCT SYMPTOMS WERE EVIDENT PRIOR TO HIS/HER EFFECTIVE DATE, ACCORDING TO THE PRE-EXISTING CONDITION LIMITATION PROVISIONS OF THE PLAN.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, consumer reporting agency, I insurance or reinsuring company, or employer having certain information about me or my children to give to **BAF Financial & Insurance (Bahamas) Limited**, or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness.

I UNDERSTAND the information obtained by use of the Authorization will be used by **BAF Financial & Insurance (Bahamas) Limited** to determine eligibility for insurance and eligibility for benefits. **I ALSO AUTHORIZE BAF FINANCIAL & INSURANCE (BAHAMAS) LIMITED** to release any information obtained to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

Signature of Applicant		Date	
Signature of Spouse		Date	
Signature of Dependent Child over 18		Date	
Signature of Agent		Date	

BAF Financial & Insurance (Bahamas) Limited
Independence Drive, P.O. Box N-4815
Nassau, The Bahamas
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www.bafmedsafe.com
medsafeadmin@mybafsolutions.com

HEALTH HISTORY QUESTIONNAIRE

A COPY OF THIS QUESTIONNAIRE MUST BE COMPLETED FOR EACH PERSON LISTED ON THE APPLICATION

Name		Date of Birth	

A. MEDICAL INFORMATION - *Please provide details for any questions answered "Yes", indicating the number and letter on the Additional Information sheet provided.*

		Yes	No
1	Has the person named above ever had or been treated for:		
a	Acquired Immune Deficiency Syndrome (AIDS), Chronic Pneumonia, Kaposi's Sarcoma, Heart Disorder, Cancer, Alcoholism or Alcohol Abuse, Drug use or Drug Addiction?	☐	☐
b	Disease or disorder of the Urinary Tract, Digestive System, Reproductive System, Liver, Back, Bones or Joints?	☐	☐
c	Diabetes, High Blood Pressure, Asthma, Chest Pain, Seizure disorder, Stroke, Rheumatic Fever, Heart Murmur, Tuberculosis, Hepatitis or Blood disorder, elevated cholesterol?	☐	☐
d	Tumor or any other abnormal growth, Thyroid disorder, Paralysis, Arthritis, Nervous or Mental Disorder?	☐	☐
e	Any other Physical disorder or deformity?	☐	☐
2	Has the person named above had medical expenses exceeding $1,000 over the past three (3) years?	☐	☐
3	Is the person named above:		
a	Currently taking any prescribed medication or under medical treatment?	☐	☐
b	Currently pregnant?	☐	☐
c	Totally or partially disabled?	☐	☐
4	Within the last three years, has the person named above:		
a	Consulted any doctor? If "Yes", please specify:	☐	☐
b	Been hospitalized or undergone medical studies? If, "Yes", please specify:	☐	☐
c	Received Medical treatment overseas? If "Yes", please specify:	☐	☐

5 Name of any other doctor you have seen in the last year, If there is none, please state.

Name	
Facility	Telephone Number:

6 Name of your Personal/Family Physician. If there is none, please state the name of the last Physician seen.

Name	
Facility	Telephone Number:

7. Have you ever been advised to have any diagnostic test, treatment or surgery which has not been completed? ☐ Yes ☐ No. If "Yes", please explain below:

If the person named above is less than 5 years old, please provide the following information:

Was the child delivered at full term?	Were there any complications at birth?	Method of childbirth
☐ Yes ☐ No	☐ Yes ☐ No	☐ Normal Delivery ☐ C-Section
Number of days in hospital after birth:	Weight at birth:	Current weight:

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I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my children to give to **BAF Financial & Insurance (Bahamas) Limited**, or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness.

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Signature of Applicant/Dependent		**Date**	

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