RF&G life Insurance Company
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Print Form

GROUP HEALTH & GROUP LIFE APPLICATION

Section 1 EMPLOYEE INFORMATION

Name of Employer: _____

Name of Employee: _____ Date of Birth: _____

Occupation & Duties: _____

Date of Employment: _____ Social Security #: _____

Age: _____ Height: _____ Weight: _____ Place of Birth: _____ Gender: _____

Employee is to be enrolled in: ☐ Group Health Insurance ☐ Group Life Insurance

Type of Group Health Plan: _____ Sum Insured (Group Life): _____

Annual/Lifetime Maximum (Group Health): _____ Deductible (Group Health): _____

Additional Group Health Benefits: ☐ Dental & Vision Additional Group Life Benefits: ☐ AD&D ☐ TPD

Applying for (applicable to Group Health): ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & child(ren)

Are you a resident of Belize? Yes ☐ No ☐ Are you a citizen of Belize? Yes ☐ No ☐
Are you a citizen of any other country other than Belize? Yes ☐ No ☐
If, yes, please state which country: _____

Section 2 DEPENDENT INFORMATION Complete for each person to be insured. (Use additional sheet if necessary)

Names of Dependents	Relationship	Sex	Height	Weight	Date of Birth	Social Security No.

Section 3 PRIOR INSURANCE COVERAGE *(if applicable)*

Have you or your dependents been covered under any health insurance plan within the last 90 days? ... ☐ Yes ☐ No
If, Yes, to qualify for prior coverage credit; please provide the following information on all coverage in force in the past 12 months.

Names of Insurance Company _____ Ins. Co. Phone No.: ( ) _____

Effective date of Prior Coverage _____ Termination Date (if applicable) _____

Type of Coverage: ☐ Individual or ☐ Group Policy No.: _____

Coverage was for (check all that apply): ☐ Self ☐ Spouse ☐ Children

Complete information & sign on reverse

Section 4 MEDICAL INFORMATION Please give details to any "Yes", answers below

1. Have you or anyone applying for coverage in the past 10 years had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	☐	☐	Thyroid or Pituitary Disorder	☐	☐
Nervous, Mental or Emotional Disorder	☐	☐	Diabetes or Sugar in Urine	☐	☐
Drug or Alcohol Abuse	☐	☐	Disease of the Muscle	☐	☐
Epilepsy or Cerebral Palsy	☐	☐	Bone or Joint Disorder	☐	☐
Abnormal Blood Pressure	☐	☐	Arthritis, Rheumatism, Bursitis	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Lungs or Respiratory System	☐	☐
Blood Disorder or Varicose Veins	☐	☐	Emphysema, Tuberculosis, Chronic Obstructive		
Digestive or Gastrointestinal Tract	☐	☐	Pulmonary Disease or Asthma	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Liver, Pancreas or Kidney	☐	☐	Skin or Collagen Disease	☐	☐
Rectum, Prostate or Hernia	☐	☐	Cancer, Leukemia or Hodgkin's Disease	☐	☐
Genitourinary System	☐	☐	Lymphatic Vessels or Glands	☐	☐
Breast or Reproductive Organs	☐	☐	Any Physical Deformity or Defect	☐	☐
Endocrine or Adrenal Disorder	☐	☐			

2. Has anyone applying been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats or enlarged glands?..... ☐ YES ☐ NO

3. Are you or any dependent (whether applying for coverage or not) currently pregnant, anticipating surgery or is anyone applying for coverage disabled, restricted or unable to perform the normal activities of daily living and selfcare? ..... ☐ YES ☐ NO

4. During the past 5 years, has anyone applying for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? ..... ☐ YES ☐ NO

5. Is anyone currently taking medication?..... ☐ YES ☐ NO

6. Is there any existing medical condition or problem, including any undiagnosed symptoms that have not otherwise been indicated on this application? For "yes" answer provide details below. ..... ☐ YES ☐ NO

Use this space to give details to any "YES" answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Name of Insured(s)	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition

Section 5 To be answered by the employee. If any of these questions are answered "Yes", give complete details.

	EMPLOYEES		
	YES	**NO**	**DETAILS**
A. Have you or do you intend to engage in hand gliding, parachuting, Vehicle racing, skin or scuba diving or any other hazardous sport or hobby?	☐	☐	
B. Have you or do you intend to fly other than as a passenger? (i) Over the last 6 months have you done more than 50 sets of Flying as a passenger?	☐	☐	
C. Do you smoke cigarettes, cigarillos, cigars or a pipe? (If yes, indicate how many per day of each).	☐	☐	
D. Have you ever been a cigarette smoker in the past? (If yes, indicate how many cigarettes per day, and when and why you quit).	☐	☐	
E. Have you ever been told to quit cigarette smoking for Medical reasons? (Give details and name of physicians).	☐	☐	

Section 6 **(Applicable to Group Life Insurance Coverage ONLY)**

I, the undersigned request that in the event of my death, all proceeds from my Group Life Insurance policy be paid to:

Primary Beneficiary

Name: _____

Address: _____

Relationship: _____ Date of Birth: _____ Percent:_____

Name: _____

Address: _____

Relationship: _____ Date of Birth: _____ Percent: _____

Name: _____

Address: _____

Relationship: _____ Date of Birth: _____ Percent: _____

Name: _____

Address: _____

Relationship: _____ Date of Birth: _____ Percent:_____

Contingent Beneficiary

Name:_____

Address: _____

Relationship: _____ Date of Birth: _____ Percent:_____

Trustee Information (For minors stated as beneficiaries)

Name: _____

Address: _____

Relationship: _____ Date of Birth: _____

Section 7

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

I hereby apply for health/life insurance to be issued solely and entirely in reliance upon the written answers to the foregoing questions and I agree that the insurance provided only covers the applicant and the dependants listed above who are accepted. I have read the answers to the questions before signing this application and the answers are correctly written as given by me to the best of my knowledge; true and complete. I understand and agree that no coverage shall be in force until the first premium is paid and coverage is approved.

A photographic copy of this authorization and acknowledgement shall be as valid as the original.

I understand that no Agent is authorized to change or notify in any way any applicable coverage section of the certificate or suppress any of the Company's requirement. I also agree that CorVel, or other organization, institution or person or its reinsurers that have any records or knowledge of me or my health, or my dependants listed in this application, to give to RF&G Life Insurance Co. Ltd. and its reinsurers any-such information.

DECLARATION: I hereby declare that all proposed Insured persons are domiciled in Belize for at least nine months and that my dependants or I do not participate in semi-professional or professional sports. I also confirm that there are no known or ongoing illnesses that I am aware of.

_____	_____	_____
PLACE	DATE	SIGNATURE OF PROPOSED INSURED

Official Use ONLY

Effective Date of coverage: _____

Approved by: _____ Date: _____