INDIVIDUAL HEALTH INSURANCE APPLICATION FORM

PLEASE PRINT ALL INFORMATION

Name (First, Middle Initial, Last)	Gender	DATE OF BIRTH			Age Last B-Day	Birth Place State	Height	Weight	Social Security Number
		Month	Day	Year					
Proposed Insured:									
Spouse:									
Child:									
Child:									
Child:									
Child:									

Telephone Number:	Fax: Number:	**COVERAGE INCLUDES:**
		Deductible:
Type of Plan:	Annual Maximum:	Mailing Address:
Email Address:		
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:		
Employer:	Occupation:	Duties:
Spouse:	Occupation:	Duties:

HEALTH DECLARATION

All Questions are to be answered for each person to be covered. Additionally, provide details to "YES" answer in next section of this application. Please circle the specific disease.

	Insured		Spouse		Children	
	Yes	No	Yes	No	Yes	No
1, Have you ever received treatment or joined an organization for alcoholism or drug addiction?						
2. Do you have a personal physician? If yes, please state:						
3. Are YOU, your spouse, or proposed insured dependants pregnant?						
4. Have you used tobacco in any form during the past 12 months? If yes,						
5. Have you used cocaine, marijuana, heroin or any other illicit drug?						
6. Do YOU consume alcoholic beverages? If yes, type, amount and frequency:						
7, Do YOU participate in any hazardous sports?						
HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR:	Insured		Spouse		Children	
	Yes	No	Yes	No	Yes	No
8, Epilepsy, nervous breakdown, or any disorder of the brain or nervous system?						
9. High blood pressure, dizziness, shortness of breath, pain or pressure in the chest?						
10, Any disorder of the heart or blood vessels?						
11. Tuberculosis or any disorder of the lungs, bronchial tubes, throat, or respiratory system?						
12, Allergies, hay fever, or asthma?						
13. Ulcer, colitis, or any disorder of the stomach, intestines, rectum, gall bladder, or liver?						
14, Hemorrhoids or rectal polyps, or any disorder of the prostate?						
15, Sugar or albumin or blood in urine, or any disorder or the kidneys, urinary system, female or male organs?						
16, Diabetes, gout, or any disorder of the thyroid or other glands?						
17. Any disorder of the eyes, skin, muscle, bones or joints?						
18. Cancer, tumor, or Cyst?						
19. Any disorder of the ears, including otitis media?						
20, Acquired Immune deficiency Syndrome (AIDS\·or AIDS Related Complex (ARC)?						
21, Treatment for infertility, miscarriage, or abortion?						
22. Any disorder or injury involving the spine?						
23, Are you covered under any other Health Plan (Private/Government)?						

DURING THE PAST FIVE YEARS, HAVE YOU:	Insured		Spouse		Children	
	Yes	No	Yes	No	Yes	No
24. Consulted, been examined, or received treatment by any physician or practitioner:						
25. Had an X-ray, electrocardiogram, or any laboratory test or study?						
26. Had observation or treatment at a clinic, hospital, or sanitarium?						
27. Had or been advised to have a surgical operation?						
28. Consulted a psychiatrist or psychologist?						
29. Received medical treatment for any disease, condition, or disorder not indicated above?						
30. Are you using regular medication? Please give details of medication.						

State the details below where the answer is "yes".

QUESTION NUMBER	NAME	ILLNESS OR INJURY	DATES OF TREATMENT	DATE OF RECOVERY	NAME OF PHYSICIAN AND/OR HOSPITAL

AUTHORIZATION AND ACKNOWLEDGEMENT STATEMENT

I hereby apply for health 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.

The Company shall not be liable under this application until it has been received and approved, and the full first as premium stipulated is paid to RF&G Life Insurance Company. This policy shall be deemed to have effect as of the policy approval date. Information given in your application maybe made available to other Legal Insurance, Third Party Administrator (TPA), Re-Insurers & medical institutions upon request.

I understand that no Agent is authorized to make change nullify in any way any applicable coverage section of the policy or to suppress any of the Company's requirement.

I hereby confirm that all expenses for Medical and Laboratory requirements requested by RF&G Life Insurance Company Limited will be fully paid by me if I choose not to accept the terms and conditions of the approved coverage. Also, I am aware and agree that an Administration Fee is payable by me if I choose not to accept the terms and conditions of the approved coverage.

DECLARATION: I hereby declare that all proposed Insured persons are domiciled in Belize for at least nine months and that my answers to medical questions asked in this application are answered truthfully and to the best of my knowledge. I also confirm that there are no known or ongoing illnesses that I am aware of.

_____	_____	_____
PLACE	DATE	SIGNATURE OF PROPOSED INSURED

Comments of the Insurer: OFFICE USE ONLY

Premium:
Deductible:
Requested Effective Date:

x _____ _____

for RF&G LIFE INSURANCE COMPANY LIMITED DATE: _____

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A Roe Group Company