

Application for **Disability Insurance**

Second Floor,
RoyalStar House
John F. Kennedy Drive
P.O. Box EE-15606
Nassau, Bahamas



Applicant Information

Individual		Group		NIB number	
Last name		First		Initial	
Phone		DOB (Day/Month/Year)		Age	
Permanent residence		City		Country & Zip	
Mailing address		City		Country & Zip	
Email address		Fax number			

Is the proposed applicant considered a Politically Exposed Person (PEP)?	Yes	No
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Employer Information		
Employer name	Type of business/ industry	Employer phone
Employer address	City	Country & Zip
Email address		Employer fax
Occupation and duties		Annual Income \$

Policy owner (if not the applicant)	NIB number
Full name or company name	Relationship to insured
Address	City Country Zip
Occupation and duties	Annual Income \$

Plan Selection (choose one)	Disability Benefit Amount
30-Month Income Protection Plan Basic with Cash Value	\$ /month
60-Month Income Protection Plan Basic with Cash Value	\$ /month
To Age 65 Income Protection Plan with Occupational Coverage without Occupational Coverage	\$ /month
Professional Income Protection Plan Basic with Cash Value	\$

Frequency of Payment	Mode of Payment	Please provide Customer ID below if you are an existing client.
Annual Semiannual Monthly	Cheque (make payable to: New Providence Life Insurance Company Limited) Credit Card Wire Transfer Payroll Deduction	
Total Premium Due (This amount must match the total premium shown on the Proposal PDF)		\$
Once your application has been submitted, you will receive a Customer ID and Certificate Number . Please use those numbers to submit your payment information in the Online Payment Portal .		

Part I Questions Provide Complete Answers for the Applicant

For "Yes" answers, give details in the "Part II Details" section or complete the appropriate questionnaire required by the company.

Part A: Medical Questions		Yes	No
1. Has any applicant ever been advised to or received medical consultation, care, treatment or taken medication for: (Please circle each condition)			
a	Heart or circulatory system (including but not limited to infarction, high blood pressure, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins or arteries) and/or any other symptom regarding the circulatory system or heart, which if referred to a doctor would result in a diagnosis.		
b	Respiratory system (including but not limited to deviated septum, sinusitis, polyps or cyst, asthma, bronchitis, emphysema, bronchiectasis, tuberculosis) and/or any other symptom regarding the respiratory system, which if referred to a doctor would result in a diagnosis.		
c	Gastrointestinal system (including but not limited to gastro esophageal reflux, hiatal hernia, gastritis, gastric or duodenal ulcer, duodenitis, diverticulosis, diverticulitis, polyps, colitis, gallbladder diseases) and/or any other symptom regarding the gastrointestinal system, which if referred to a doctor would result in a diagnosis.		
d	Urinary system (including but not limited to kidney diseases, stones, infections, urinary tract disease, bladder disorders, and prostate diseases) and/or any other symptom regarding the urinary system, which if referred to a doctor would result in a diagnosis.		
e	Musculoskeletal system (including but not limited to back disorders, spinal cord disorders, rheumatism, arthritis/arthrosis, gout, lumbago, osteoporosis, deformity, herniated disc) and/or any other symptom regarding the musculoskeletal system, which if referred to a doctor would result in a diagnosis.		
f	Neoplastic disorders, benign or malignant tumors (cancer)		
g	Endocrine system (including but not limited to hypophysis gland diseases, thyroid, parathyroid, diabetes, ovaries and adrenal glands disorders) and/or any other symptom regarding the endocrine system, which if referred to a doctor would result in a diagnosis.		
h	Sexually transmitted diseases or acquired immunodeficiency syndrome (AIDS) or ARC (AIDS-related complex).		
i	Female reproductive system (including but not limited to disorders of menstrual cycle, ovaries, uterus including cervix, endometriosis, pelvic inflammatory diseases, fallopian tubes, vagina, miscarriages, cesarean section). Breast disorders (including but not limited to fibrocystic diseases, tumor) and/or any other symptom regarding the female reproductive system or breast, which if referred to a doctor would result in a diagnosis.		
j	Male reproductive system (including but not limited to prostate, testes, and penis) and/or any other symptom regarding the male reproductive system, which if referred to a doctor would result in a diagnosis.		
k	Neurological system (including but not limited to convulsions, epilepsy, paralysis, multiple sclerosis, cerebral infarction, Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.		
l	Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.		
m	Any skin disorders (including but not limited to acne, psoriasis, melanomas, and carcinomas).		
n	Hematologic and lymphatic system (including but not limited to anemia, leukemia, multiple myeloma, Waldenstrom's macroglobulinemia, spleen disorders and other blood and coagulation disorders) and/or any other symptom regarding the hematologic and lymphatic system, which if referred to a doctor would result in a diagnosis.		
o	Collagen diseases (including but not limited to rheumatoid arthritis, systemic lupus erythematosus, scleroderma) and/or any other symptom regarding collagen diseases, which if referred to a doctor would result in a diagnosis.		
2. Has any applicant:			
a	Had health examinations or routine medical check-ups?		
	Had any abnormalities?		
b	Been a patient in a hospital, clinic or sanatorium?		
3. Is any applicant pregnant?			
4. Has any applicant been recommended to undergo a surgery that is still pending?			
5. Is any applicant currently taking any prescribed medication or under medical treatment? Has any applicant been advised of future treatment?			
6. Has any applicant been or is any applicant currently addicted to drugs or alcohol? Has any applicant ever used or is any applicant using drugs not prescribed by a physician? Has any applicant been in or is any applicant currently in a rehabilitation program for addiction or substance abuse?			
7. Has any applicant received treatment or been diagnosed for any disorders or conditions? Is any applicant taking prescribed medication for any condition not mentioned above?			
8. Has any applicant been declined, postponed or rated in any way? Please give details.			
9. Has any applicant been involved in the operation of an aircraft or involved in any hazardous sport? Please give details.			
10. Have you been continuously at work full time performing the usual duties of your occupation for the past 6 months?			

Part B: Tobacco and Tobacco Use Questions		Yes	No
1. Do you Smoke?			
2. Cigarettes?			
a	If "yes," how many per day?		
3. Cigars, Pipe, E-Cigarettes or any other form of tobacco?			
a	If "yes," specify the type and frequency?		

Telephone Interview

Please be advised you may be contacted by a representative to verify your health history.

The best time to call would be: _____ a.m. _____ p.m. Phone number: _____

Printed name of applicant _____

Signature of applicant _____ Date _____ / _____ / _____
Day Month Year

Part II Details *Give Full Details Below*

If you answered "Yes" to any of the questions in the "Part I Questions" section, please complete this form or indicate the required information below:

No.	Applicant's name	Diagnosis, treatments, results	Date	Physician/Hospital details

Family or personal physician's information	
Name:	Telephone number:
Address:	

Beneficiary Designation			
<i>Total designated beneficiary share percentage must equal 100%. Please use last page of the application to list more as needed.</i>			
<i>All benefits are assigned to the designated beneficiary.</i>		<i>In the event of death of beneficiary.</i>	
Beneficiary	Percentage:	Contingent Beneficiary	Percentage:
	%		%
Name:		Name:	
Relationship:		Relationship:	
Date of birth: <i>Day/Month/Year</i>		Date of birth: <i>Day/Month/Year</i>	
Address:		Address:	
Phone:		Phone:	

Applicant's Statement

I hereby certify all responses and declarations contained in this application are true, complete and correct and I understand and agree any inaccuracy or omission in responses will constitute grounds for the Company to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the Company cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or pre-existing conditions, the Company reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand the broker, agent or agency receiving this application does not have the authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in the application must be set forth in writing on this application. I further understand this application will become part of the insurance policy to be issued and the Company will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the Company offering this insurance can be held liable for any circumstance if the broker, agent or agency, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator. All premium payments must be made payable to the Company. The Company is not responsible for payments made in cash or payable to a third party.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first premium is made, and the policy issued, subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent residents of the United States or others who reside in the United States.

It is understood if the Insured changes occupational duties from the original occupation disclosed to Company without first notifying the Underwriters and obtaining its written agreement to the amendment of the Insurance (subject to the payment of such reasonable additional premium as the Underwriters may require as the consideration for such agreement), then no claim shall be payable in respect of any Accident arising out of or in the course of such occupation.

Signature of proposed applicant _____ Date _____ / _____ / _____
Day Month Year

Medical Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility and payment of claim benefits under this policy. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

Signature of proposed applicant _____ Date _____ / _____ / _____
Day Month Year

I personally solicited and completed this application. All medical and non-medical questions were asked of each proposed insured and their answers were recorded as given or the answers were made by the proposed insured in his or her own handwriting.

Agent signature / Witness: _____ Agent code: _____

Agent email: _____ Date _____ / _____ / _____
Day Month Year

For electronic delivery of policy documents, check this box and provide email address below.

Email address: _____

Email or Mail completed, signed enrollment form to:

New Providence Life Insurance Company Limited

Second Floor, RoyalStar House, John F. Kennedy Drive • P.O. Box EE-15606 • Nassau, Bahamas

Tel: (242) 326-6779, (242) 677-6945, (242) 677-6946 • Fax: (242) 328-4141 • Email: administrator@newprovidencelife.com