Cash Protector Plan
Enrollment Form

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

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Applicant Information

❑ Individual ❑ Group

NIB number	

Primary Insured			Sex	Date of Birth			Age	Height (ft/inch)	Weight (lbs)
First Name	I.	Last Name		Day	Mth	Year			

Permanent Residence (Including City & Country)	Mailing Address	
Telephone Number	**Email Address**	**Fax Number**

Employer or Other Postal Address	Occupation and Duties	
Telephone Number	**Email Address**	**Fax Number**

Benefit Amount	❑ $15,000	❑ $20,000	❑ $30,000	❑ $40,000	❑ $50,000
Cash Protector Plan – Basic				*Select if applicable*	❑
Cash Protector Plan with Cash Value				*Select if applicable*	❑

Total Annual Premium
Modal Factor (Monthly .092 + $2.00 or Semiannual .55) x Annual Premium
Modal Premium Due

Please provide Customer ID if you are an existing client.

Customer ID:

Part I: Medical Information. *If you answer "Yes" to any questions in Part I, you are not eligible for this plan.*		*Yes*	*No*
1	Have you ever been treated or diagnosed with any form of cancer, or a condition that potentially could be cancerous such as elevated PSA, abnormal PAP smear, abnormal mammogram, abnormal biopsy, organ mass or tumor?	❑	❑
2	Have you ever been diagnosed with a neurological or autoimmune disease such as epilepsy, Meniere's disease, multiple sclerosis, Lou Gehrig's disease, also called amyotrophic lateral sclerosis (ALS), Parkinson's disease, Alzheimer's disease, lupus or rheumatoid arthritis?	❑	❑
3	Have you ever been treated or diagnosed as being HIV positive?	❑	❑
4	Have you ever been diagnosed with myocardial infarction (heart attack), coronary arterial disease, angina pectoris, or arteriosclerosis?	❑	❑
5	Have you ever been diagnosed or treated for stroke, transient ischemic attack (TIA or mini stroke) cardiac arrhythmia or diabetes mellitus with hypertension?	❑	❑
6	Have you ever been diagnosed or treated with any coagulation disease such as deep venous thrombosis, pulmonary embolism or aneurism?	❑	❑

Part II: The following questions are about tobacco and tobacco use.		*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 that you may be contacted by a representative from the New Providence Life Insurance Company Limited home office 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

Frequency of Payment	Mode of Payment
❑ Annual ❑ Semiannual ❑ Monthly	❑ Cheque* ❑ Credit Card ❑ Wire Transfer ❑ Payroll Deduction **Please make cheques payable to: New Providence Life Insurance Company Limited*

*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**.*

Beneficiary Designation

Primary Beneficiary(ies)		Percentage (must equal 100%)
Name:	Relationship:	
Address:	DOB: *Day/Month/Year*	%
Name:	Relationship:	
Address:	DOB: *Day/Month/Year*	%

Contingent Beneficiary(ies)		Percentage (must equal 100%)
Name:	Relationship:	
Address:	DOB: *Day/Month/Year*	%
Name:	Relationship:	
Address:	DOB: *Day/Month/Year*	%

Applicant's Statement

I hereby certify all responses and declarations contained in this application are true, complete, and correct and I understand and agree that any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim or to invalidate or cancel any of the insurance coverage applied for. In the event the insurer 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 insurer 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 authority to modify or waive any portion of this application or any coverage, conditions, or restrictions contained in the insurance policy applied for and that all information requested in this application must be set forth in writing on this application. I further understand that this application will become part of the insurance policy to be issued and that the insurer 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 that is offering this insurance. Neither the administrator or the company that is 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.

It is understood that the insurance applied for shall not become effective until this application is approved and accepted by the insurer, full payment of the first term premium is made, and the policy issued is 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. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country of residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

I understand under the Cash Protector Plan I am participating in is a **LIMITED BENEFIT POLICY.** All statements contained in the application shall, in the absence of fraud, be deemed representations and not warranties. These benefits are provided under an insurance policy underwritten by New Providence Life Insurance Company Limited and subject to exclusions, limitations, terms, and conditions of coverage as set forth in the Master Policy which includes, but is not limited to, limitations for previously diagnosed illnesses.

This is not basic health insurance or major medical coverage and is not designated as a substitute for basic health insurance or major medical coverage. This is a Cash Protector Plan that provides limited coverage. The limitations are disclosed in the policy and certificate, which are made available at the time of enrollment.

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 Primary Insured _____

Signature of Owner *(if different than Proposed Primary)* _____
If business insurance, show the title of officer and name of firm

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
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) 325-8291 • Email: administrator@newprovidencelife.com