Dependent Addition Form

RoyalStar House
John F. Kennedy Drive
Nassau, Bahamas

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Part I: Main Insured Information

Last Name	First Name	M.I.
Customer Number	**Email Address**	**Phone (Home/Cell)**

Part II: Dependent(s) Personal Information

Dependent 1

Last Name	First Name		Relationship to Main Insured ☐ Spouse ☐ Child	
Place of Birth	DOB Day/Month/Year	Sex ☐ Female ☐ Male	Height (ft/inch)	Weight (lbs)

Dependent 2

Last Name	First Name		Relationship to Main Insured ☐ Spouse ☐ Child	
Place of Birth	DOB Day/Month/Year	Sex ☐ Female ☐ Male	Height (ft/inch)	Weight (lbs)

Dependent 3

Last Name	First Name		Relationship to Main Insured ☐ Spouse ☐ Child	
Place of Birth	DOB Day/Month/Year	Sex ☐ Female ☐ Male	Height (ft/inch)	Weight (lbs)

Part III: Additional Information for Dependent(s) Under 10 Years of Age

Has any applicant proposed for coverage ever been advised to or received medical consultation, care, treatment or taken medication for: *(if answer is affirmative please provide dependent name and explanation in the additional comments section on page 2)*		Yes	No
(a)	Any congenital diseases, hereditary condition or any deformity?	☐	☐
(b)	Any complications relating to pregnancy or birth?	☐	☐
(c)	Disorder of Psychomotor Development (delay in sitting, crawling, standing, walking or speaking)?	☐	☐
(d)	Any repetitive acute illnuss such as otitis, tonsillitis, pneumonia, etc.?	☐	☐
(e)	Any Neurological System Diseases, (convulsions of any cause, meningitis)?	☐	☐
(f)	Respiratory Diseases, (asthma)?	☐	☐
(g)	Cardiovascular Diseases (heart or blood vessels)?	☐	☐
(h)	Any Digestive Disease (stomach, esophagus, liver, intestines)?	☐	☐
(i)	Genito-Urinary Disease (genitals, kidneys, ureter, bladder, urethra)?	☐	☐
(j)	Any Mental Disorder, Psychological or Behavioral disorders (Autism, ADHD).	☐	☐
(k)	Any previous surgeries?	☐	☐
(l)	Ever been hospitalized?	☐	☐
(m)	Ever received any type of physical therapy?	☐	☐
(n)	Ever suffered from any condition not mentioned in this questionnaire?	☐	☐
(o)	In the event of treatment due to a newborn please provide: gestational age (weeks) at which the baby was born.		

Dependent Addition Form *(continued)*

Part IV: Additional Information for Dependent(s) Over 10 Years of Age

Has any applicant proposed for coverage ever been advised to or received medical consultation, care, treatment or taken medication for: *(if answer is affirmative please provide dependent name and explanation in the additional comments section below)*		Yes	No
(a)	Cardiovascular system (infarction, high blood pressure, angina, rheumatic fever, cardiac defects, arrhythmias, disease of veins, arteries or any other)	☐	☐
(b)	Respiratory system (otitis, deviated nasal septum, sinusitis, nasal polyps or cyst, asthma, bronchitis, emphysema, bronchietasis, tuberculosis or any others)	☐	☐
(c)	Gastrointestinal system (gastro esophageal reflux, hiatal hernia, gastritis, gastric or duodenal ulcer, duodentis, diverticulosis, intestinal polyps, colitis, gallbladder disease or any others)	☐	☐
(d)	Urinary system (kidney disease, stones, urinary tract infections, bladder disorders, prostate disease or any others)	☐	☐
(e)	Musculoskeletal system (back disorders, spinal cord disorders, rheumatism, arthritis/arthrosis, gout, lumbago, osteoporosis, deformity, herniated disc or any other?	☐	☐
(f)	Neoplastic disorders (Benign or Malignant)	☐	☐
(g)	Endocrines system (Hypophysis gland diseases, Thyroid, Parathyroid, Diabetes, Ovaries or Adrenal glad disorders)	☐	☐
(h)	Sexually transmitted diseases HIV, Acquired Immuno Deficiency Syndrome (AIDS), ARC (AIDS-related complex)	☐	☐
(i)	Female reproductive system (disorders of menstrual cycle, ovaries, uterus including cervix, endometriosis, fallopian tubes, vagina, pelvic inflammatory diseases, miscarriages, cesarean section or any other)	☐	☐
(j)	Male reproductive system (disorders of prostate, Testes, Penis or any other)	☐	☐
(k)	Neurologic System (convulsions, epilepsy, paralysis, Multiple Sclerosis, stroke, Alzheimer's disease, Dementia or any other)	☐	☐
(l)	Liver disorders (Fatty liver, Cirrhosis, Hepatitis or any other)	☐	☐
(m)	Skin disorders (acne, psoriasis, melanomas, carcinomas or any other)	☐	☐
(n)	Hematologic and Lymphatic system (anemia, leukemia, multiple myeloma, Spleen's disorders or any other blood or coagulation disorders)	☐	☐
(o)	Collagen's Diseases (Rheumatoid Arthritis, Systemic Lupus Erythematosus, Scleroderma or any other)	☐	☐
(p)	Have you or any dependent requesting been a drug or alcohol addict; take or have taken unprescribed drugs; are or have been under a rehabilitation program for any addiction or intoxicating substance abuse?	☐	☐
(q)	Have received treatment, or have been diagnosed with any disorder, condition or are taking prescription medication for any condition "not" mentioned above?	☐	☐

Additional Comments:

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Main Insured Signature _____ Date _____ / _____ / _____
Day Month Year

Dependent Signature _____ Date _____ / _____ / _____
(over age 18)
Day Month Year

Mail completed, signed form to:

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