Critical Disease Cash 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

	First Name	I.	Last Name	Sex	Date of Birth			Age	Height (ft/inch)	Weight (lbs)
					Day	Mth	Year			
Main										
Spouse										
Child #1										
Child #2										
Child #3										
Child #4										
Child #5										

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

Cancer Benefit Amount Selected ($10,000, $25,000, $50,000)	$
Critical Disease Cash Plan – Basic	❑ Yes ❑ No
Critical Disease Cash Plan with Cash Value	❑ Yes ❑ No

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

Please provide customer number if you are an existing client.

Customer Number:

Part I: Medical Information. *If you answer "Yes" to any questions in Part I, you are not eligible for coverage.*		Yes	No
1. Have you ever been diagnosed, hospitalized, treated or been advised by a Licensed Health Care Practitioner/Physician, or had diagnostic procedures for:			
a	Leukemia, Hodgkin's disease, Malignant Melanoma, Sarcoma or any internal cancer, or had radiation or chemotherapy for any of these conditions?	❑	❑
b	Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Condition (ARC)?	❑	❑
c	ALS (Lou Gehrig's disease), Cerebral Palsy, Cystic Fibrosis, Multiple Sclerosis, Muscular Dystrophy, Reye's syndrome, Polio, Leukemia, internal cancer, or Malignant Melanoma?	❑	❑

Part II: Family History. *If you answer "Yes," please describe below.*	Yes	No
2. Has any parent, brother or sister of ANY person APPLYING FOR COVERAGE ever had cancer or any other known hereditary disorder?	❑	❑
3. If you answered "yes" to question 2, please complete the following table for each member of the immediate family. If there is a family history of cancer, please specify type of cancer and any staging information if known.		

Family Member	*Current Age*	*State of Health and Nature of Condition*	*Age at Onset*	*Cause of Death* *(if applicable)*	*Age at Death*
Father:					
Mother:					
Brothers:					
Sisters:					

Beneficiary Designation

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

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

Frequency of Payment

❑ Annual
❑ Semi Annual
❑ Monthly

Mode of Payment

❑ Check ❑ Credit Card ❑ Wire Transfer ❑ Payroll Deduction

$15.00 fee applies for wire transfer • When paying by Credit Card, please complete below Credit Card authorization section.

Credit Card Authorization

Name as it appears on the credit card:

Billing Address:

❑ VISA ❑ MASTERCARD ❑ AMERICAN EXPRESS ❑ DINERS ❑ DISCOVER

Credit Card Number:

__ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiration Date: ____ /____

Amount to be charged:

BD $ _____

I, the undersigned, authorize New Providence Life Insurance Company, Limited to debit from this credit card the above specified amount, related to the insurance premium. I understand that each year, in order to renew my policy, I will need to provide a new credit card authorization form. In addition, I acknowledge, that failure to provide such authorization form may result in cancellation of my policy.

Signature_____ Date _____ /_____ /_____
Day Month Year

Payments by Check

Please make checks payable to New Providence Life Insurance Company, Limited (NPL).

Telephone Interview

Please be advised that you may be contacted by a representative from the New Providence Life 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

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 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 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 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 Critical Disease Cash 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 Critical Disease Cash 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. 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: _____

Mail completed, signed enrollment form to:

New Providence Life, 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