Minor Insured Alone Health
Application Form

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

NEW PROVIDENCE
LIFE INSURANCE COMPANY LIMITED

Parent or Legal Guardian Information

NIB number	

First Name	I.	Last Name	Sex	Date of Birth			Age	Relationship to Applicant
				Day	Mth	Year		

Permanent Residence (Including City & Country)	Mailing Address	Home Telephone
Employer or other postal address:	Email:	
	Work telephone:	
Occupation and duties:		Fax:

Insured's Personal Information

NIB number	

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

Frequency of Payment

❑ Annual ❑ Semiannual
❑ Monthly

Mode of Payment

❑ Cheque* ❑ Credit Card ❑ Wire Transfer ❑ Payroll Deduction

**Please make cheques payable to: New Providence Life Insurance Company Limited*

Deductible:	Optional Cover/Rider:	Plan Name:

*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**.*

Total Annual Premium
(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 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 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. Is any applicant presently covered by another insurance company? If "Yes", please provide.		❑	❑
a	Company's name:	*Please, attach copy of the actual insurance policy and receipt for payment of the policy, if replacing.*	
b	Expiration date of coverage: _____ /_____ /_____		
11. Does any insured intend to replace or change existing policy in connection with this application? If "Yes", please complete (a & b) below.		❑	❑
a	Company's name:		
b	Effective date of coverage: _____ /_____ /_____ Expiration date of coverage: _____ /_____ /_____		

Parent/Legal guardian signature: _____ Initials: _____

Part II Details

If you answered "yes" to any of the questions on the previous page, please complete this form.

No.	Applicant's Name	Diagnosis, Treatments, Results	Date	Physician / Hospital Details

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

Initials: _____

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 insurer to deny a claim, 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 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 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 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.

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. 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.

_____ Date _____ /_____ /_____

Signature of parent or legal guardian on behalf of the applicant

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.

_____ Date _____ /_____ /_____

Signature of parent or legal guardian on behalf of the applicant Day Month Year

I, _____ (Parent's Name), hereby certify that I am the parent/legal guardian of _____ (Name of Minor), and take full financial and legal responsibility for the payment and maintenance of the terms of this certificate.

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

Email address: _____

The name of the Witness "is required"

I certify that I have accurately provided all the information given by the applicant and given him/her a copy of the insurance brochure.

Agent signature / Witness: _____ Agent code: _____

Agent email: _____ Date: _____

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