GUYANA AND TRINIDAD MUTUAL LIFE INSURANCE COMPANY LIMITED
27-29 Robb & Hincks Streets, Georgetown Guyana
Tel. #: 225-7910-9 Ext: 2347, 2346
Fax: 592-225-9397
E-mail: grouplp@gtm-gy.com

Health Plan for Individual and Family
APPLICATION
GUYANA

PART A — GENERAL INFORMATION

APPLICANT'S LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET NUMBER AND NAME	HOME TELEPHONE NO.
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ COMMON LAW	BUSINESS TELEPHONE NO.

APPLICANT'S EMPLOYER (IF SELF EMPLOYED PRINT "SELF EMPLOYED")	SPOUSE'S EMPLOYER (IF NOT EMPLOYED PRINT "NOT EMPLOYED")
APPLICANT'S OCCUPATION (TYPE OF BUSINESS NOT JOB TITLE)	SPOUSE'S OCCUPATION (NOT JOB TITLE)

Are you still working at your place of employment? ☐ Yes ☐ No

Are you already covered by a GTM Health Plan? ☐ Yes ☐ No

Are you covered by another Health Insurance? ☐ Yes ☐ No
If "yes" provide name of Insurance Co.

POLICY NO. _____ EFFECTIVE DATE _____

PART B — PLAN CHOICE

We apply for ☐ Gold ☐ Silver ☐ Bronze

☐ INDIVIDUAL

☐ INDIVIDUAL + 1

☐ FAMILY

☐ AIR AMBULANCE COVERAGE

☐ TRAVELLERS HEALTH INSURANCE

☐ MATERNITY BENEFIT

Note: Maternity benefits and conditions relating to pregnancy are not payable unless a (9) month waiting period is served following the effective date of the insured coverage.

PART C — INDIVIDUALS TO BE COVERED

Provide first name of applicant and all family members to be covered.
Plus last name of any member if different from the applicant's (when family coverage is applied for)

LAST NAME / FIRST NAME	SEX	BIRTH DATE D	M	Y	AGE	EFF. DATE	REL	HEIGHT FT.	IN.	WEIGHT	NAMES & ADDRESSES OF PHYSICIANS
APPLICANT											
SPOUSE											
DEPENDENT CHILD (SON / DAUGHTER)											
DEPENDENT CHILD (SON / DAUGHTER)											
DEPENDENT CHILD (SON / DAUGHTER)											
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DEPENDENT CHILD (SON / DAUGHTER)											
DEPENDENT CHILD (SON / DAUGHTER)											

PART D — BILLING OPTIONS

INITIAL PAYMENT
Amount submitted with my application to cover first _____ month's payment is $ _____ + Travellers Health Insurance $ _____

Date _____ + Air Ambulance Coverage $ _____ = Total Premium Paid $ _____

Premiums are payable thirty (30) days in advance of the month for which coverage is to be provided.

PART E — MODE OF PAYMENT & CONDITIONAL RECEIPT

SUBSEQUENT PAYMENTS

The under-mentioned payment methods are available. Please indicate your choice (√)

Choice is ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

CONDITIONAL RECEIPT (This receipt is null and void if altered or modified, or if the cheque in payment of the premium deposit is not honoured by the bank)

RECEIVED FROM _____ $ _____

Dollars subject to the terms and conditions set forth, in payment of the premium. This receipt does not constitute a temporary insurance and does not prove insurability. This payment is subject to the agreement in this application and to the following: That the proposed insureds are a good risk to the Company.

GUYANA AND TRINIDAD MUTUAL LIFE
INSURANCE COMPANY LIMITED

PART F — MEDICAL QUESTIONNAIRE FOR APPLICANT AND DEPENDANTS

HEALTH QUESTIONNAIRE

SECTION A — CHECK EACK ITEM YES OR NO. To the best of your knowledge and belief, has any person named in this application had ***within the last seven years,*** or does such person now have any of the following?

YES	NO			YES	NO	
☐	☐	(a)	Cancer, tumor or other growth	☐	☐	(j)	Arthritis, rheumatism, extreme deformity, amputation(s), back or spinal trouble, gout.
☐	☐	(b)	Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus Seropositivity (HIV +) (Positive HIV Test)	☐	☐	(k)	Heart trouble, abnormal blood pressure (hypertension or hypotension), anemia, rheumatic fever.
☐	☐	(c)	Kidney stones, kidney or bladder trouble, urinary frequency or burning.	☐	☐	(l)	(Female irregular or excessive menstrual bleeding, reproductive system disorders, infertility, breast condition.
☐	☐	(d)	Goitre, thyroid trouble, diabetes.				
☐	☐	(e)	Seizure disorder, central nervous system disorder	☐	☐	(m)	(Female) is currently pregnant; expected date of delivery.
☐	☐	((f)	Substance abuse (drug or alcohol dependency, abuse or addiction)	☐	☐	(n)	(Male) Prostate trouble, reproductive system disorders, infertility.
☐	☐	(g)	Gall bladder trouble, hernia, stomach or intestinal trouble, ulcers, haemorrhoids, liver disorder.	☐	☐	(o)	Outpatient counselling, any psychiatric or psychological counselling, or any nervous or mental disorder.
☐	☐	(h)	Cataract or other eye condition.				
☐	☐	(i)	Tuberculosis, lung condition, asthma, bronchitis	☐	☐	(p)	Sexually transmitted diseases.

SECTION B — In addition to the conditions listed in SECTION A, to the best of your knowledge and belief, within the past five years, has any person named in this application:

(a) Had a physical examination?
(b) Excluding physical examination, consulted a physican, health care provider, or other individual or facility for medical or surgical treatment, advice or screening for any condition not listed in **SECTION A**?
(c) Had any departure from good health not previously mentioned in any of the above questions for which treatment or advice may or may not have been sought?

SECTION C — If you have checked "Yes" to any part of **SECTION A** or **SECTION B**, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalisation, surgery, and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

PATIENT'S FULL NAME	DIAGNOSIS OR CONDITION	DURATION DATES FROM TO	EXPLAIN TREATMENT INCLUDING ALL MEDICATIONS, HOSPITALISATIONS, SURGERY, DIAGNOSTICS TEST RESULTS AND PHYSICIAN'S/HOSPITAL NAME	RECOVERY CHECK ONLY ONE BOX
				☐ Full ☐ Partial
				☐ Full ☐ Partial
				☐ Full ☐ Partial
				☐ Full ☐ Partial
				☐ Full ☐ Partial

Are you or any dependant listed using or expect to be using medication or serum in the next 3 months?

APPLICANT YES ☐ NO ☐ **SPOUSE / CHILDREN** YES ☐ NO ☐

If you and/or any dependant listed is/are currently using medication or serum complete the section below.

NAME OF PERSON	NAME OF THE DRUG/MEDICATION/SERUM	MONTHLY COST OF DRUG/MEDICATION/SERUM	STRENGTH OF THE DRUG/MEDICATION/SERUM	DAILY DOSAGE OF THE DRUG/MEDICATION/SERUM	LENGTH OF TIME ON THIS DRUG/MEDICATION/SERUM

PART G — DECLARATION (All applicants must complete **PART G)**

NOTE: THE INFORMATION PROVIDED ON THIS FORM IS CONSIDERED CONFIDENTIAL

I/We hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as of this date.

I/We hereby authorise any licensed physician, medical practitioner, hospital, clinic, medical facility or organisation which has records of my/our health to release such information to GTM Life. A photocopy of this signed authorisation shall be as valid as the original.

I/We understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application are not covered by the agreement unless fully disclosed on this application. Failure to disclose such information could result in denial of claim and the cancellation or modification of the agreement. I/We understand and agree that coverage shall not become effective until approved by GTM Life.

SIGNATURE OF APPLICANT _____ **SIGNATURE OF SPOUSE** _____

ID# **ID#**

DATED _____ _____ _____ **AGENT'S SIGNATURE** _____ **AGENT'S CODE #** _____

DAY MONTH YEAR

NOTE: If after 60 days of receiving this receipt, you do not have your "Membership Card" or your premium has not been reimbursed, please notify GTM LIFE 27-29 Robb & Hincks Streets, Georgetown Tel.: Health "Hot" Line — 226-6118 or 225-7910-9 - Ext: 2347, 2346.