

## 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		MIDDLE INITIAL									
STREET NUMBER AND NAME		HOME TELEPHONE NO.									
MARITAL STATUS SINGLE MARF		BUSINESS TELEPHONE NO.									
APPLICANT'S EMPLOYER (IF SELF EMPLOYED PRINT "SELI	YER (IF N	R (IF NOT EMPLOYED PRINT "NOT EMPLOYED")									
APPLICANT'S OCCUPATION (TYPE OF BUSINESS NOT JOB	SPOUSE'S OCCUPATION (NOT JOB TITLE)										
Are you still working at your place of employment?											
Are you already covered by a GTM Health Plan?											
Are you covered by another Health Insurance? If "yes" provide name of Insurance Co.	? Yes No										
POLICY NO.	OLICY NO EFFECTIVE DATE										
		PAR1	В-	-PLA	N CH	OICE					
We apply for Gold Silver Bronze								AIR AMBI	ULANCE COVERAGE		
☐ TRAVELLERS HEALTH INSURANCE											
☐ INDIVIDUAL+1	☐ 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										_	
PARI	<u> </u>	- IND	טועו	UAL	310	BE CO	VERI	ED			
Provide first name of applicant and all family members a Plus last name of any member if different from the app				nily co	werad	na is annli	ed for	١			
, , , , , , , , , , , , , , , , , , , ,	_	`						HEIGHT	WEIGHT NAMEO & ARRESON		
LAST NAME FIRST NAME	SEX	D	RTH DA M	Y	AGE	EFF. DATE	REL	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)											
	P/	ART [	) — B	BILLIN	IG OI	PTIONS					
PART D—BILLING OPTIONS  INITIAL PAYMENT Amount submitted with my application to cover first month's payment is \$ Travellers + Health \$									— ]		
Date Air Ambulance = Total Premium Paid \$								1			
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 ( $\sqrt{\ }$ )											
Choice is  Monthly  Quarterly  Semi-Annually  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)									le\		
RECEIVED FROM  \$									4)		
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											



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## PART F—MEDICAL QUESTIONNAIRE FOR APPLICANT AND DEPENDANTS

HEALTH QUESTIONNAIRE  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					
		mor or other grov mmune Deficienc			☐ (j)	Arthritis, rheumatism, e amputation(s), back or				
	Syndrome	(AIDS), AIDS Rela	ated Complex		(k)	Heart trouble, abnorma	l blood pressure			
(ARC), Human Immunodeficiency Virus (hypertension or hypotension), anemia, Seropositivity (HIV +) (Positive HIV Test) rheumatic fever.										
(c) Kidney stones, kidney or bladder trouble, urinary frequency or burning.										
(d) Goitre, thyroid trouble, diabetes. infertility, breast condition.										
(€	(Female) is currently pridate of delivery.	regnant; expected								
		abuse (drug or a cy, abuse or addi			(n)	(Male) Prostate trouble disorders, infertility.	, reproductive system			
	g) Gall bladde	er trouble, hernia,	stomach or intestina	al 🔲	(o)	Outpatient counselling,				
(r		cers, haemorrhoid r other eye condi				psychological counselling or mental disorder.	ng, or any nervous			
		sis, lung condition	(p)	Sexually transmitted dis	seases.					
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:										
<ul><li>(a) Had a physical examination?</li><li>(b) Excluding physical examination, consulted a physican, health care provider, or other individual or facility for medical or surgical</li></ul>										
t	reatment, advi	ce or screening for	or any condition not	listed in SECTIO	N A?					
	Had any depar may not have I		ealth not previously n	nentioned in any	of the abov	e questions for which trea	atment or advice may or			
<b>SECTION C</b> — If you have checked "Yes" to any part of <b>SECTION A</b> or <b>SECTION B</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	DIAGNOSIS					TIONS, HOSPITALISATIONS,	RECOVERY			
FULL NAME	OR CONDITIO	ON FROM	TO SURGERY, D	IAGNOSTICS TEST RE	ESULTS AND P	HYSICIAN'S/HOSPITAL NAME	CHECK ONLY ONE BOX			
							Full Partial			
							Full Partial			
							Full Partial			
							Full Partial			
							T uii Faitiai			
							Full Partial			
Are you or any dependant listed using or expect to be using medication or serum in the next 3 months?  APPLICANT SPOUSE / CHILDREN YES NO YES NO YES NO NO YES NO										
NAME OF PERSON		NAME OF THE	MONTHLY COST OF	STRENGT		DAILY DOSAGE OF THE	LENGTH OF TIME ON THIS			
		MEDICATION/SERUM	DRUG/MEDICATION/SERI			DRUG/MEDICATION/SERUM	DRUG/MEDICATION/SERUM			
		PART G DE	CLARATION (All	annlicants must	complete	PART G)				
NOTE: THE INFORMA	TION PROVIDE		S CONSIDERED CONF		. complete	PART G)				
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										
II	ID#									
DATED		AGENT'S	SIGNATURE			AGENT'S CODE #				
DAY MONTH	H YEAR	AGENT O								
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.										