BUPA CORPORATE CARE ENROLLMENT FORM FOR CMB CARDHOLDERS

CMB
CARIBBEAN MERCANTILE BANK

Bupa

1. APPLICANT'S INFORMATION

Last Name		First Name			
Place of Birth		Date of Birth	MM/DD/YYYY	Gender: ☐ Male ☐ Female	
Address	Street Address				
Telephone Number		E-mail address			
Occupation		Employer			
☐ Approves to charge account in name of:					

☐ Monthly ☐ Annualy

	Monthly	Annual
☐ Cardholder Applicant only	AWG 131.04	AWG 1,572.47
☐ Cardholder + Spouse	AWG 262.07	AWG 3,144.94
☐ Cardholder + Child(ren)	AWG 262.07	AWG 3,144.94
☐ Cardholder + Family	AWG 393.12	AWG 4,717.41

2. DEPENDENT'S INFORMATION

Last Name		First Name			
Place of Birth		Date of Birth	MM/DD/YYYY	Gender: ☐ Male ☐ Female	
Relation to applicant					
Last Name		First Name			
Place of Birth		Date of Birth	MM/DD/YYYY	Gender: ☐ Male ☐ Female	
Relation to applicant					
Last Name		First Name			
Place of Birth		Date of Birth	MM/DD/YYYY	Gender: ☐ Male ☐ Female	
Relation to applicant					

3. ACKNOWLEDGEMENT

By signing or completing this form, I understand and agree that the benefits and conditions of the medical plan are established in separate documents that Caribbean Mercantile Bank N.V. must provide to each plan Member (See the Table of Benefits, Membership Guide and Terms and Conditions).
Bupa Insurance Company (the "Insurance Company") reserves the right to accept or reject my enrollment application. The coverage provided will become effective on inception date of the policy.
Restrictions: New members and/or dependents that currently have or have ever been diagnosed with the following conditions are not able to apply: Active Malignant Tumors and/or Cancer, Autoimmune Disease(s), Chronic Hepatitis, or Muscular Dystrophy.
Waiting Period: A waiting period of twelve (12) months applies to all pre-existing conditions.
It is understood that coverage is effective for twelve (12) months from the first of the month following approval and may be renewed for a similar period upon renegotiation of its terms at least thirty (30) days prior to its termination, provided such coverage is not first cancelled by the Applicant or Group Sponsor.

4. SIGNATURE

Signature of Applicant		Date	MM/DD/YYYY

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