



合作保險顧問有限公司
CIS Insurance Brokers Limited

Application for Group Health Insurance

Policyholder Details

Name: _____
Address: _____
Industry/Business Nature: _____
Contact Person: _____ Tel: _____ Fax: _____
E-mail Address: _____

Affiliated Companies

1. Name: _____
Address: _____
2. Name: _____
Address: _____

Participating Classification

Plan *	Definition	Dependent Coverage	Eligibility Date
1		<input type="checkbox"/> Yes <input type="checkbox"/> No	A) Existing Member <input type="checkbox"/> on the Policy Effective Date <input type="checkbox"/> on the day next following _____ months of employment <input type="checkbox"/> other _____
2		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3		<input type="checkbox"/> Yes <input type="checkbox"/> No	B) Future Member
4		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> on the day next following _____ months of employment <input type="checkbox"/> other _____

Policy Details

Policy Effective Date: (dd-mmm-yyyy) _____
Policy Anniversary Date: (dd-mmm) _____

Premium to be payable in advance as per Premium Payment Mode

Claim Settlement Mode:

Autopay to Employee Cheque to Employee
 Cheque to Policyholder

Premium to be Contributory / Non-contributory:

Employees	Dependants
<input type="checkbox"/> Contributory <input type="checkbox"/> Non-Contributory	<input type="checkbox"/> Contributory <input type="checkbox"/> Non-Contributory

It is understood that:

1. if members are not required to contribute for insurance, all eligible persons will be allowed to become insured;
2. if members are required to contribute for insurance, all eligible person will be given an opportunity to contribute for the insurance;
3. the applicant agrees to furnish CIS Insurance Brokers Ltd. with such information as it may require concerning eligible persons or classes thereof;
4. on acceptance of this application, the policy is to be issued to the policyholder named in accordance with the information shown on this application.

* To be submitted for reference.

Applicant

Authorized Signature & Company Chop (Day Month Year)

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