



APPLICATION FOR PERMISSION OR EXTENSION TO RESIDE IN THE CAYMAN ISLANDS AS A DEPENDANT OF A CAYMANIAN

The completed application form should be sent to:
The Director, Customs and Border Control, P.O. Box 898, Grand Cayman KY1-1103, CAYMAN ISLANDS
PLEASE DO NOT LEAVE ANY QUESTION BLANK. IF A QUESTION DOES NOT APPLY TO YOU, INSERT "NOT APPLICABLE" OR "N/A" IN THE SPACE PROVIDED.
Use separate sheet of paper if necessary. Retain a copy of all applications and attachments submitted to CBC.

Please choose one option:

APPLICATION FORM CONTAINS 9 PAGES

- Application for Permission to reside as a Dependant of a Caymanian (PDC)
- Application for an Extension of Permission to reside as a Dependant of a Caymanian (PDE)

Date of Expiry:

Part 1 - To Be Completed By the Applicant

1. Surname (Last Name) Maiden Name Given Names (First Names)

2. Nationality Country of Birth Date of Birth Male Female

3. Passport number Date of Issue Place of Issue Date of Expiry

4. Address in the Cayman Islands (if already resident) House No.: Street name:

District P.O. Box & KY Telephone:

Email Address

5. Present address (if different from above)

6. Marital Status Married Divorced Separated Widowed Single

Place and Date of Marriage (if any)

7. I am a citizen of the following country(s)

I hold passport(s) of the following country(s)

8. In addition to being a citizen of those countries I am also a permanent resident or entitled to live in the following countries-



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9. Dates and addresses of all places where you have lived for more than 6 months during the past 10 years, if other than stated in reply to question 5.

From	To	Address
D/MMM/YY	D/MMM/YY	
D/MMM/YY	D/MMM/YY	
D/MMM/YY	D/MMM/YY	

10. Total annual income (CI\$ _____)

Sources of income: 1) _____ 2) _____ 3) _____

11. Please provide details of Caymanian relative that you intend to reside with.

Name	Date of Birth D/M/Y	Nationality	Relationship
	D/MMM/YY		

11a. Address of Caymanian relative above

House Number _____ Street name _____
 District _____ P.O. Box & KY _____ Telephone _____
 Email _____

11b. Do you intend to reside at the above address? If not, please provide intended address.

House Number _____ Street name _____
 District _____ P.O. Box & KY _____ Telephone _____

12. Have you ever had a permit to work refused or permission to reside revoked, or not renewed upon application in any country during the past 10 years?

13. Do you currently have health insurance coverage? Yes No If yes please provide the following:

Name of Provider: _____ Policy #: _____

Are your premiums (payments) up to date? Yes No If no, why not? _____

14. Do you suffer from any communicable disease or infirmity of mind or body? Yes No If yes please provide details:

15. Have you ever been convicted of a criminal offence in any country? Yes No If yes please provide details:

DECLARATION

I declare the information contained in this application to be correct to the best of my knowledge and belief and am aware that it is a criminal offence to make any statement or representation that is false in a material particular which I know to be false or do not believe to be true.

Signature _____ Date (dd/mm/yy) _____



APPLICATION FOR PERMISSION OR EXTENSION TO RESIDE IN THE CAYMAN ISLANDS AS A DEPENDANT OF A CAYMANIAN

PART 2 - To Be Completed By The Caymanian Sponsor

1. Surname (Last Name) _____ Maiden Name _____ Given Names (First Names) _____

2. Nationality _____ Country of Birth _____ Date of Birth D/MMM/YY Male Female

3. Passport number _____ Date of Issue D/MMM/YY Place of Issue _____ Date of Expiry D/MMM/YY

4. Address in the Cayman Islands _____

P.O. Box: _____ Telephone: _____ Email _____

5. Present address (if different from above) _____

6. Marital Status Married Divorced Separated Widowed Single

Place and Date of Marriage (if any) _____

7. Total annual income (CI\$) _____

Sources of income: 1) _____ 2) _____ 3) _____

8. Total monthly expenses (CI\$) _____

9. Please list your existing dependants (Use separate sheet of paper, if necessary).

Name	Date of Birth D/M/Y	Nationality	Relationship
_____	<u> D/MMM/YY </u>	_____	_____
_____	<u> D/MMM/YY </u>	_____	_____

10. What is your relationship to the applicant who is applying as a dependant? _____

11. Will you be responsible for paying health insurance coverage payments for the dependant? Yes No

12. Do you agree to be responsible for any and all expenses incurred by dependant? Yes No

DECLARATION

I declare the information contained in this application to be correct to the best of my knowledge and belief and am aware that it is a criminal offence to make any statement or representation that is false in a material particular which I know to be false or do not believe to be true.

Signature _____ Date (dd/mm/yy) _____



AFFIDAVIT

This affidavit is in support of an application for the grant of permission to reside in the Cayman Islands as the Dependant of Caymanian and is to be completed by the Caymanian Sponsor.

I _____ of _____

make oath and say as follows:-

1. That _____ is wholly dependent upon me. **Choose one option only**
 substantially dependent upon me.

2. That I will be wholly responsible for him her during their stay in the Cayman Islands.

Signature _____

Date _____

Sworn before me at _____, Cayman Islands, this _____ day of _____ 20_____

Justice of the Peace/Notary Public _____

Warning: It is an offence under the Customs and Border Control Act for any person to make, cause or allow to be made any return, statement or representation which is false in a material particular and which he knows to be false or which he does not believe to be true. A person found guilty of this offence is liable on summary conviction in respect of a first offence, to a fine of \$5,000.00 and to imprisonment for one year.

I declare that I understand and accept the Warning given above.

Signature of Caymanian Sponsor

Date (DD/MM/YY)

Signature of Dependant

Date (DD/MM/YY)



PHOTOGRAPH TEMPLATE - Applicant only

Surname (Last Names)

Given Names (First Names)

Maiden Name (if applicable)

File Number (if known)

(Also known as "Reference Number")

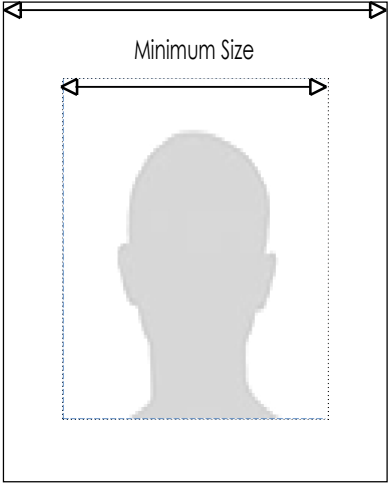
Application Date D/MMM/YY

Date of Birth D/MMM/YY

Full Face

Maximum Size

Minimum Size



Full Face Photograph

Do Not Use Staples!

Photographs may be taped or glued to the picture diagrams.

Instructions:

- Provide Full Face photo (1 photo).
- Print Last Name, First Name(s), and Date of Birth on the back of each photograph.
- The photograph must:
 - be a "passport type" photograph
 - be in colour
 - be taken within the past 12 months
 - show full face (shoulders and above)
 - have no head covering
 - have a plain white background
 - be between 45mm by 35mm (1.77 inches by 1.38 inches) and 63mm by 50mm (2.5 inches by 2 inches), see diagram below
 - be unmounted
 - be printed on normal photographic paper
 - if digital, have resolution of at least 800 dpi (dots per inch)
- Blurred photographs will not be accepted.
- Stick-on labels will not be accepted.



PERMISSION OR EXTENSION TO RESIDE IN THE CAYMANIAN ISLANDS AS A DEPENDANT OF A CAYMANIAN CHECKLIST

This list is a summary of general requirements for all applicants. The Director of CBC reserves the right to request additional information or documentation as he sees fit.

The Applicant

- Application form duly completed. **Please do not leave any question blank. If a question does not apply to you, insert "not applicable" or "n/a" in the space provided**
- A non-refundable CI\$150 grant or extension application fee Grant or extension fee of CI\$150 and non-refundable repatriation fee of CI\$200
- Cover letter addressed to the Director of CBC from Caymanian stating detailed reasons why the dependant should reside in the Cayman Islands
- A certified/notarized copy of your Birth Certificate
- Original signed and sealed, Police Clearance Certificate, less than 6 months old, from last place of residence, if 18 years of age or older.
- 1 full face passport sized photograph **AND** 1 profile passport sized photograph.
- Original medical declaration cover letter. Note: The **full** medical is only required every 3 years, including the HIV/VDRL lab report (**HIV/VDRL is required every six months**) for all dependants 18 years old and over, and will be kept on record by the attending physician or medical examiner.
- Three written references from persons (not related to applicant or spouse) who have known you for at least 3 years. The referees may be Caymanian or Non-Caymanian. Each reference must be in a sealed envelope, signed across the seal by the referee, with the name of the applicant on the outside.
- A notarized English translation of all documents where the originals are presented in a foreign language
- Proof of adequate health insurance acceptable on island (if applying for an extension, please provide proof of health insurance for the past three (3) years)
- Proof of annual income, if applicable

The Caymanian Sponsor (Part 2)

- Application form duly completed. **Please do not leave any question blank. If a question does not apply to you, insert "not applicable" or "n/a" in the space provided**
- Proof of being Caymanian
- A certified/notarized copy of your Birth Certificate
- A certified/notarized copy of your Marriage Certificate, if applicable
- Bank Reference Letters (local or overseas) Proof of annual income (Job letter)
- Affidavit of responsibility

Important Notice: As a data controller, Customs and Border Control (CBC) complies with the Data Protection Act. The personal data provided in this form will be used to determine any application for the examined individual to live and/or study in the Cayman Islands. We may verify the information that has been provided, including contacting you directly if we have questions about this application. Visit www.gov.ky/cbc/ for our full privacy notice.



MEDICAL DECLARATION COVER LETTER

(TO BE SUBMITTED TO CUSTOMS AND BORDER CONTROL)

Date
D D M M Y Y Y Y

Reference No. (if known)

Part 1: To be completed by the applicant

First Name

Last Name

Date of Birth
D D M M Y Y Y Y

Country of Birth

Contact:
Cell

Home

Email

Sponsor*

School Name**

Purpose of Medical:

Student Visa
 Student Visa Dependant

Permission - Dependant of a Caymanian
 Extension - Dependant of a Caymanian

*Sponsor is the first and last name of the Caymanian Family member in the case of Dependant of Caymanian Applications.

**School Name is the name of the Educational Institution in the case of Student Visa Applications.

Please do not leave any section blank. If a section does not apply to you, insert "not applicable" or "n/a" in the space provided.

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MEDICAL DECLARATION COVER LETTER

(TO BE SUBMITTED TO CUSTOMS AND BORDER CONTROL)

Part 2: To be completed by the Medical Examiner

Dear Sir/Madam,

This is to certify that I have examined on
Full Name DD MM YYYY

The applicant is of good health not of good health and does not suffer does suffer

from any/a form of communicable or mental disease that would make that person a danger to the community.

Sincerely,

First Name Last Name

Medical Registration Number

Job Title

Place of Medical Examination

E-Mail Address Phone No

I hereby declare that I am a duly appointed and or certified medical examiner. I confirm that the Information and representations contained in this Medical Examination Form (CBC/MSS001(2024/06)) are true and correct to the best of my knowledge and belief. I am aware that it is a criminal offence under the Cayman Islands Customs and Border Control Act to make a statement or representation that is false or misleading and that I may be prosecuted if found in breach of this offence.

Signature of Authorizing Physician
or Medical Examiner

Official Stamp



MEDICAL EXAMINATIONS FORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

1. The Medical examinations are valid for one (1) year.
2. Chest Xrays are valid for five (5) years.
3. Medical practitioners are advised to perform any tests that might be desirable depending on the disease prevalence in the respective countries.
4. The Medical Examinations Form must be signed, stamped, or sealed and retained by the medical examiner.
5. The Cayman Islands Customs and Border Control Service reserves the right to require additional medical examinations at any time.

Part 1: QUESTIONNAIRE (to be completed by the applicant)

First Name	<input type="text"/>	Last Name	<input type="text"/>
Maiden Name	<input type="text"/>	Nationality	<input type="text"/>
Passport No.	<input type="text"/>	Country of Birth	<input type="text"/>
Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> D D M M Y Y Y Y	Sex	<input type="checkbox"/> Female <input type="checkbox"/> Male
Contact	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Cell	Home	Email
Physical Address	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Apt#	Bldg Name	House# Street Name
	<input type="text"/>		<input type="text"/>
	District	Neighborhood	
Mailing Address	<input type="text"/>	<input type="text"/>	<input type="text"/>
	P.O.Box	Postal Code	Post Office

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MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

Part 2: MEDICAL EXAMINATION (to be completed by Medical Examiner)

Is the Examinee personally known to you?	YES NO <input type="checkbox"/> <input type="checkbox"/>	If No, did you check ID?	YES NO <input type="checkbox"/> <input type="checkbox"/>
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Height (ft/in)	<input type="text"/>	Weight (lbs. in under clothes)	<input type="text"/>	Body mass index	<input type="text"/>
Peak flow rate	<input type="text"/>	Date and report of last E.C.G. if any	<input type="text"/>		
Blood pressure	<input type="text"/>	Pulse rate	<input type="text"/>		

Are the following free from any pathological condition or abnormality (Choose all applicable)*

a. Skin	YES NO <input type="checkbox"/> <input type="checkbox"/>	e. Nose	YES NO <input type="checkbox"/> <input type="checkbox"/>	i. Locomotor System	YES NO <input type="checkbox"/> <input type="checkbox"/>
b. Throat & Mouth	<input type="checkbox"/> <input type="checkbox"/>	f. Abdomen	<input type="checkbox"/> <input type="checkbox"/>	j. Nervous System	<input type="checkbox"/> <input type="checkbox"/>
c. Eyes	<input type="checkbox"/> <input type="checkbox"/>	g. Cardiovascular System	<input type="checkbox"/> <input type="checkbox"/>	k. Genito-Urinary System	<input type="checkbox"/> <input type="checkbox"/>
d. Ears	<input type="checkbox"/> <input type="checkbox"/>	h. Respiratory System	<input type="checkbox"/> <input type="checkbox"/>		

*If No to any of the above questions, provide details

Is the applicant taking any medications at present or within the last six (6) months?	YES NO <input type="checkbox"/> <input type="checkbox"/>	*If Yes, please explain	<input type="text"/>
			<input type="text"/>

Give details of any operations

Medical conditions	a. <input type="text"/>	b. <input type="text"/>
	c. <input type="text"/>	d. <input type="text"/>

Medical Examiner printed name	Date of Examination	Signature
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

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MEDICAL EXAMINATIONSFORM

(TO BE RETAINED BY THE MEDICAL EXAMINER)

Part 3: XRAY AND LABORATORY INVESTIGATIONS (to be completed by Medical Examiner)

Hospital XrayNo	<input type="text"/>	Date	<input type="text"/>	Results	<input type="text"/>
Urine: Date	<input type="text"/>	Albumin	<input type="text"/>	Sugar	<input type="text"/>
Blood Tests:	SYPHILIS	Date	<input type="text"/>	Results	<input type="text"/>
	HIV SCREEN	Date	<input type="text"/>	Results	<input type="text"/>

Medical Examiner

First Name Last Name

Medical Registration Number

Qualifications

Address of Registering Body

Mailing Address

P.O.Box Postal Code Post Office

E-Mail Address

Date of Examination	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Signature	<input type="text"/>
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Note: A medical examination before arrival in the Cayman Islands may only be completed by a practitioner fully registered as a medical doctor by the medical councils of either the United Kingdom, United States, Canada, or the Cayman Islands. If a medical examination cannot be undertaken by a practitioner who is registered in one of these countries, CBC may offer a temporary condition to allow the person to enter, however, he/she must have a medical examination completed in the Cayman Islands, by a medical doctor registered in the Cayman Islands, and the medical declaration cover letter must be submitted to satisfy application requirements.