

reside[®] blue application for coverage

2008 Reside Blue Worldwide Medical Plan – All Sections Must be Completed in Full

As described in the brochure and documentation, Reside Blue Worldwide Medical Plan is a comprehensive medical insurance program designed exclusively for the international citizen. In order to provide you and your family with the coverage you desire, please follow the directions and answer all questions in complete detail.

Please note that Reside Blue limits coverage for U.S. Citizens in the United States to 9 months during any given 12-month Policy Period. This plan is not intended to cover permanent residents of the United States.

Directions For Completing The Application

1. Please print or type all information. Illegible information will delay underwriting and processing of your coverage.
2. Each family member requesting coverage must be listed on the Application. All questions on the Application apply to all applicants requesting coverage. Answer each and every question, as it pertains to each applicant listed on the Application. All members of a family must choose the same Deductible.
3. Each section of the application must be completed in full. Any question where a "Yes" is marked must be described in detail in Section 4. Information in Section 4 must include the applicant's name, physician's name, address and phone number, address of treating facility, diagnosis, prognosis, and course of treatment. If necessary, use an additional sheet of paper to describe the condition(s) and attach it to the Application when submitted to Seven Corners.
4. The Premiums listed are annual premiums and can be paid by check, money order, VISA[®], MasterCard[®], Diners Club[®], American Express[®], or Discover[®]. Due to the inconsistent reliability of international mail, monthly, quarterly and semi-annual payments can be made by using a credit card or ACH payment. Monthly, quarterly and semi-annual payment modes are only accepted with Pre-authorization to debit your credit card or checking account on the due date of your premium installment.
5. After Seven Corners underwrites your application and determines that coverage should be issued, we will send you an ID Card and a Certificate of Coverage by mail. The Certificate of Coverage contains the full program wording and definitions. This package will also include details on how to submit a claim as well as information regarding Seven Corners' Pre-Notification Program.

All Sections Must Be Completed in Full

section 1. program options

1. Please Choose Your Policy Period Medical Deductible: \$250 \$500 \$1,000 \$2,500 \$5,000
2. Would you like to include the Dental Option: Yes No
3. Would you like to include the Sports Option: Yes No
4. Would you like to include the Hospital Daily Indemnity Option: Yes No
5. Would you like to increase the Accidental Death and Dismemberment Benefit: Yes No If yes, to what amount: _____
Primary Insured \$100,000 \$200,000 \$300,000 \$400,000 \$500,000
Spouse \$100,000
Child (each child) \$10,000
What is the Primary Insured's Annual Income? _____
Accidental Death and Dismemberment (AD&D) benefit is limited to 7 times the Primary Insured's Annual Income for persons under the age of 55. Persons over the age of 55 may be limited to a lesser amount.

Requested Effective Date: ____ / ____ / ____ (month/day/year) (Requested Effective Date must be within 60 days of application date and U.S. Citizens must leave the U.S. within 30 days of effective date. If accepted, official Effective Date will be advised by Seven Corners.)

For the AD&D benefit (including any increased amount), please provide the beneficiary:

Primary Insured: _____ Spouse: _____

Child #1: _____ Child #2: _____

Child #3: _____ Child #4: _____

section 2. applicant information:

Applicant's Name <i>(Last, First, Middle, Maiden)</i>	Sex	Relationship	Date of Birth <i>(MM/DD/YYYY)</i>	Citizenship	Height <i>Feet / Inches</i>	Weight <i>lbs</i>
		Primary				
		Spouse				
		Child #1				
		Child #2				
		Child #3				
		Child #4				

Vessel Information:

Name of Current Vessel and Country of Registry / Flag: _____

Telephone *(if available)*: (____) _____ Fax *(if available)*: (____) _____ Email *(if available)*: _____

Expected time outside U.S. during the next 12 months: _____

Countries to be visited during the next 12 months: _____

My principal residence is onboard the vessel(s) where I am employed Yes No*If you answered yes, please complete the Declaration of Residence form attached. If you answered no, please provide Non-US address in the Residence Address section below.***Address of Residence:** *(must be outside the United States)*

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Forwarding / Convenience Address:

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Home Phone: (____) _____ Business Phone: (____) _____ Fax: (____) _____

(please include area and/or country code)

Email: _____

Occupation of Primary Insured Onboard Vessel(s): _____

Occupation of Spouse: _____

Family Physician Name: _____

Address of Family Physician: _____ Phone: (____) _____

Declaration of Residence

I _____ do hereby declare, attest, certify and warrant that I am employed aboard and / or own and / or operate a registered seagoing vessel, typically spending a significant period of time sailing outside of U.S. territorial Waters.

My principal residence is the non-U.S. address provided on my application or my principal residence is on the internationally traveling vessel. I have supplied within my insurance application a mail forwarding address simply for convenience in sending and receiving mail and other communications, and not with any intent to establish or claim residency.

I understand that this insurance is not subject to individual insurance laws of the United States or of any particular State thereof, and declare that I am waiving any claim to residency in a State of the United States for purposes of this insurance.

Signature _____ Date _____

1. Do you understand this is an international program and not U.S. health insurance? Yes No2. Are you or any listed dependents currently in the United States? If yes, enter departure date below. Yes NoWhen do you plan to depart the United States: ____ / ____ / ____ *(month/day/year)*3. Are any listed dependents who are age 19, 20, 21, 22 and 23 full-time students? *(if yes, please list schools and locations)* Yes No

section 3. underwriting questions for all applicants

In order for your Application to be processed successfully, each question must be answered truthfully for all applicants. Any answers to “yes” questions must be explained in Section 4 Health History Details. In addition, answers to “yes” questions require an Attending Physicians Statement (APS) dated within the past 90 days containing detailed information and medical records.

Within the past ten (10) years, have you or any applicant sought treatment or been advised to seek treatment for, been medically advised, referred, counseled, treated, had surgery, diagnosed or currently taking prescription medicine for: (Please ‘check’ all that apply and state in detail in Section 4. Health History Details.)

yes no

- 1. Digestive system diseases or disorders (including, but not limited to: gastritis, ulcers, esophageal regurgitation, hemorrhoids, colon or rectum disorders)?
- 2. Cardiovascular and/or circulatory diseases or disorders (including, but not limited to: elevated blood pressure, hypertension, elevated cholesterol, heart attack, angina, chest pains, arteriosclerosis, coronary insufficiency, thrombosis, phlebitis, vascular afflictions, rheumatic fever, heart murmur)? If “Yes” attach Attending Physicians Statement (APS) and current blood pressure reading, dated within the past 90 days describing the cardiovascular and/or circulatory condition.
- 3. Respiratory diseases or disorders (including, but not limited to: chronic cough, bronchial asthma, bronchitis, tuberculosis, lung disorders, emphysema, respiratory insufficiency, pleurisy pneumonia)?
- 4. Diseases or disorders of the eyes, nose, ears and throat (including, but not limited to: nasal septum deviation, chronic sinusitis, cataracts, glaucoma, allergies or hay fever)?
- 5. Sexually transmitted diseases or immune deficiency disorder (AIDS / ARC), tested positive for HIV or any related illness?
- 6. Diseases or disorders of the Pancreas, Liver, Gall Bladder or endocrine disorders (including, but not limited to: obesity, pituitary or lymph glands, thyroid or metabolic disorders)?
- 7. Diabetes? (If “Yes”, complete the following)
 - a) Diabetic Type: _____ I or _____ II
 - b) Date Diagnosed: _____ / _____ / _____ (MM/DD/YYYY)
 - c) Medications: Type: _____ Dosage: _____
 - d) Controlled by diet only?: _____ Yes or _____ No
 - e) Date of last HbA1c Test: _____ / _____ / _____ (MM/DD/YYYY) HbA1c Results (1-10): _____
- 8. Diseases or disorders of the mental and nervous system (including, but not limited to: mental retardation, psychosis, mental or behavioral disorders, Down Syndrome or other chromosome disorders, depression, anxiety, chronic fatigue, eating disorders)?
- 9. Neurological disorders including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig’s disease (ALS), Parkinson’s disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient ischemic attacks?
- 10. Addictive diseases or disorders (including, but not limited to: alcoholism, chemical or drug abuse or addiction, or has any applicant used illegal drugs or used prescription medication, other than as prescribed)?
- 11. Kidney or urinary tract system diseases or disorders (including, but not limited to: kidney or bladder stones and infections)?
- 12. Cell or blood diseases or disorders (including, but not limited to: cancer, tumors, cysts, polyps or other growths of the skin or internal organs, hepatitis, leukemia or Kaposi’s sarcoma)?
- 13. Muscular or skeletal diseases or disorders and inflammation (including, but not limited to: scoliosis, arthritis, rheumatism, gout, tendonitis, joint or vertebrae disorders, osteoporosis)?
- 14. Have you or any applicant consulted a therapist, physician, chiropractor, psychologist, or health care practitioner for medical advice, medical treatment and/or preventative care? Have you or any applicant been hospitalized or undergone medical studies (including, but not limited to diagnostic tests, x-rays, electrocardiograms, radiology or blood work)?
- 15. For male applicants, diseases or disorders of the reproductive system (including, but not limited to: prostate or elevated PSA level)?
- 16. For female applicants, diseases or disorders of the reproductive system (including, but not limited to: vaginal bleeding, fibroids, nodules, fallopian tubes, ovaries or uterus)?
- 17. For female applicants, are you currently pregnant or had a complicated pregnancy or delivery? If currently pregnant, when is the expected due date? _____ / _____ / _____ (MM/DD/YYYY)
- 18. For female applicants, diseases or disorders of the breasts (including, but not limited to: cysts, nodules, calcifications or abnormal mammogram)?

section 3. underwriting questions for all applicants (continued)

- 19. Have you or any applicant ever been rejected, ridered, cancelled, or had premium increased for any Health, Life or Disability Policy?
- 20. Are you or any applicant currently hospitalized, disabled or unable to perform normal activities?
- 21. Any Congenital defect, physical disorder or deformity, or developmental problems not listed above?
- 22. In the last 12 months, have you or any applicant used any form of tobacco?
If "Yes" what form of tobacco? _____ Quantity: _____ How often: _____
- 23. Have you or any applicant recently experienced any signs, indications, symptoms, diagnosis or treatment that would cause you to believe that you currently have a new medical condition?

section 4. health history details for applicants

List details for all "YES" answers to the Section 3 Underwriting Questions (use additional paper, if necessary). Incomplete answers may delay processing or result in denial of application.

Name of Person and Question #	Condition / Diagnosis, Treatment Medical Prescribed and Results of Treatment	Duration / Dates of Treatment	Physician / Clinic Address and Telephone #

Information about prior / other coverage

yes no

- 1. Have you been covered by another medical plan at any time during the past year?
- 2. Will you be covered under any other medical plan (*individual or group*) while you are covered under this plan?

For all "YES" answers, please provide the following information. If more than one situation applies, attach a separate piece of paper to describe each situation.

Name of Insureds: _____

Policy Number: _____

Type of Plan: _____

- Spouse's employer group plan
- Other group plan
- Individual plan

Insurance Company: _____ Phone: (____) _____

Effective Date: ____ / ____ / ____ (MM/DD/YYYY) Termination Date: ____ / ____ / ____ (MM/DD/YYYY)

Reason for termination:

- Left employment
- Employer canceled plan
- Non-Renewal

section 5. declaration and enrollment request / authorization to release medical information:

I hereby apply for the Reside blue program and for the insurance provided by Certain Underwriters at Lloyd’s of London (the “Underwriter”). I hereby subscribe to the Global International Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd’s of London.

I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto is complete and true to the best of my knowledge and belief. I understand that my qualification for insurance is based upon my answers and statements herein and that this information may be verified by Seven Corners, Inc. (the “Administrator”). I understand that no one has the authority to exclude or direct me to exclude any information sought by this form. I understand that the Administrator will rely on all information on this Application in determining whether or not to issue coverage and that any incorrect or incomplete information may result in a claim denial or loss of coverage.

I understand that benefits may be limited or excluded for conditions for which any insured person has received any medical diagnosis or treatment, or taken any medication, or realized the manifestation of a condition before his or her effective date, according to the pre-existing conditions limitations provisions of the plan.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my dependents to give Seven Corners, Inc. or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to, information about: physical condition(s), health history(ies), avocation(s), age(s), occupation(s), and personal characteristics. This authorization includes information about drugs, alcoholism, mental illness, or communicable diseases.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Administrator to determine eligibility for benefits. I ALSO AUTHORIZE the Administrator to release any information obtained to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize.

I UNDERSTAND that as a resident of a foreign jurisdiction, I may be subject to foreign laws with respect to the type and form of coverage in which I am enrolling. I also understand and agree that responsibility for complying with those foreign laws rests solely on me.

I UNDERSTAND that no coverage is effective until I am notified in writing by the Administrator and advised of the official Effective Date. I also UNDERSTAND that if I am not accepted for coverage by the Administrator, the sole obligation of the Administrator and the Underwriter is to return the premium. I also UNDERSTAND that coverage in the United States is limited to 6 months during any one 12 month policy period. I also UNDERSTAND that Lloyd’s of London operates as an unauthorized insurer in most U.S. states and that claims may not be made against a state guarantee insurance fund. I UNDERSTAND and AGREE that this program is issued outside the United States and that the coverage may not comply with the minimum requirements set forth by any insurance jurisdiction, within or outside the United States.

I UNDERSTAND that this program is not, nor does it intend to be, a general United States health insurance policy.

I ALSO UNDERSTAND any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature of Applicant or Guardian

Date

Signature of Applicant’s Spouse (if applicable)

Date

