

reside® prime worldwide medical plan

Policy Period Medical Premiums Effective January 1, 2012

worldwide coverage including united states and canada (geographical treatment area a)

Age	If you choose a \$250 Policy Period Deductible		If you choose a \$500 Policy Period Deductible		If you choose a \$1,000 Policy Period Deductible		If you choose a \$2,500 Policy Period Deductible		If you choose a \$5,000 Policy Period Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
19 through 29	\$1,021	\$1,597	\$886	\$1,422	\$709	\$1,029	\$613	\$885	\$481	\$753
30 through 39	\$1,101	\$1,763	\$942	\$1,588	\$762	\$1,150	\$662	\$1,010	\$520	\$838
40 through 44	\$1,467	\$1,989	\$1,342	\$1,747	\$1,073	\$1,345	\$924	\$1,223	\$721	\$1,057
45 through 49	\$1,698	\$2,039	\$1,531	\$1,885	\$1,182	\$1,474	\$1,063	\$1,307	\$869	\$1,082
50 through 54	\$2,019	\$2,219	\$1,809	\$2,033	\$1,445	\$1,619	\$1,338	\$1,459	\$1,074	\$1,176
55 through 59	\$2,629	\$2,554	\$2,327	\$2,319	\$1,900	\$1,773	\$1,609	\$1,564	\$1,350	\$1,308
60 through 64	\$3,693	\$3,496	\$3,453	\$3,215	\$2,747	\$2,552	\$2,591	\$2,406	\$2,178	\$1,915
65 through 69	\$7,386	\$6,641	\$7,125	\$6,242	\$6,622	\$5,675	\$5,119	\$4,724	\$4,496	\$4,144
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child*	\$970	\$970	\$842	\$842	\$674	\$674	\$582	\$582	\$457	\$457
Child Alone** Age 14 Days to 18	\$1,021	\$1,021	\$886	\$886	\$709	\$709	\$613	\$613	\$481	\$481

worldwide coverage excluding united states and canada (geographical treatment area b)

Age	If you choose a \$250 Policy Period Deductible		If you choose a \$500 Policy Period Deductible		If you choose a \$1,000 Policy Period Deductible		If you choose a \$2,500 Policy Period Deductible		If you choose a \$5,000 Policy Period Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
19 through 29	\$771	\$1,206	\$670	\$1,074	\$535	\$776	\$463	\$669	\$363	\$569
30 through 39	\$815	\$1,304	\$697	\$1,175	\$563	\$851	\$490	\$748	\$385	\$620
40 through 44	\$1,093	\$1,482	\$999	\$1,302	\$799	\$1,002	\$689	\$911	\$537	\$788
45 through 49	\$1,256	\$1,509	\$1,133	\$1,395	\$874	\$1,092	\$787	\$967	\$643	\$801
50 through 54	\$1,524	\$1,676	\$1,365	\$1,535	\$1,091	\$1,223	\$1,010	\$1,102	\$810	\$888
55 through 59	\$1,972	\$1,915	\$1,745	\$1,739	\$1,425	\$1,329	\$1,207	\$1,173	\$1,013	\$980
60 through 64	\$2,751	\$2,605	\$2,573	\$2,395	\$2,046	\$1,901	\$1,930	\$1,793	\$1,624	\$1,427
65 through 69	\$5,465	\$4,914	\$5,273	\$4,620	\$4,901	\$4,199	\$3,788	\$3,496	\$3,327	\$3,067
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child*	\$732	\$732	\$637	\$637	\$508	\$508	\$440	\$440	\$345	\$345
Child Alone** Age 14 Days to 18	\$771	\$771	\$670	\$670	\$535	\$535	\$463	\$463	\$363	\$363

premiums for optional benefits

AD&D Principal Sum Rider:		Dental Rider:	Sports Rider:	Hospital Indemnity Benefit Rider:
Benefit	Policy Period Premium	For U.S. Citizens: \$359 per person per coverage period	\$240 per person per coverage period	Benefit is an additional \$150 per night for a covered hospital admission, maximum thirty (30) nights per policy period.
\$100,000	\$143			
\$200,000	\$286	For non-U.S. Citizens: \$508 per person per coverage period	<i>(if selected for one, then all applicants must purchase the option)</i>	\$145 per person per coverage period
\$300,000	\$429			
\$400,000	\$572	<i>(if selected for one, then all applicants must purchase the option)</i>		<i>(if selected for one, then all applicants must purchase the option)</i>
\$500,000	\$715			
Child \$10,000	\$15			

* The Dependent Child Premium is available when at least one parent (legal guardian), of a natural or legally adopted unmarried child at least fourteen (14) days old and under nineteen (19) years of age (or under twenty-four (24) years of age if attending a university full-time and must rely on parents for support), is also covered under the same program. **Children applying without an insured parent or guardian on the same program must use the Child Alone rates.

If the Applicant desires to pay premiums in two, four, or twelve installments per Policy Period, they must do so by credit card payment only. Seven Corners will automatically debit the credit card on the due date of the premium installment. The Premium Installment Factors to be applied to the Total Premium are as follows:

One Payment per Policy Period 1.00 / Two Payments per Policy Period 0.55 / Four Payments per Policy Period 0.28 / Twelve Payments per Policy Period 0.10

IMPORTANT NOTICE: The premiums referenced above are applicable for the initial three hundred and sixty-four (364) day coverage period, only after the Applicant has been accepted by Seven Corners. Seven Corners reserves the right to increase the stated premiums based upon the Applicant's medical condition at the time of application and underwriting. Applicants with chronic and/or severe medical conditions may be declined. At each renewal period, Seven Corners will inform the Applicant of the renewal premium for each subsequent coverage period based upon the Applicant's age and deductible category.

Attention Applicants: Certain Underwriters at Lloyd's of London, operates as an approved Surplus Lines market in the United States. The premiums listed above include a general Surplus Lines Tax. Your State of Residence may warrant an additional Surplus Lines Tax, Stamping Fee, and administration fee. Upon receipt and review of your application, Seven Corners will inform you if additional Surplus Lines Taxes and fees will apply. If so, Seven Corners will request the payment of the additional Surplus Lines Taxes and fees from you prior to issuing coverage. The additional Surplus Lines Taxes and fees shall be listed on the declaration page of your policy. For Tramount Insurance Company Limited, the premiums listed above include an Administrative Fee which shall be listed on the declaration page of your policy. There will not be any variation in the amount of this fee.

reside® prime application for coverage

2012 Reside Prime Worldwide Medical Plan – All Sections Must be Completed in Full

As described in the brochure and documentation, Reside Prime 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 Prime limits coverage in the United States to 180 days during any given three hundred and sixty-four (364) day 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, 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.
4. The Premiums listed are Policy Period 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, installment payments (options include two, four, or twelve payments per Policy Period) can be made by using a credit card or ACH payment. The installment payment options 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 reviews your Application and determines that coverage should be issued, we will provide you with an ID Card and a Certificate of Coverage, underwritten by either LLOYD'S of London or Tramont Insurance Company Limited. Your residence address determines which insurance carrier will provide your coverage. Pricing and benefits are identical for both Lloyd's of London and Tramont. The Certificate of Coverage contains all coverage details. You will also receive 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. Coverage Option:

- Worldwide Coverage Including the United States and Canada (*Geographical Treatment Area A*) or
 Worldwide Coverage Excluding the United States and Canada (*Geographical Treatment Area B*)

Be certain to choose the correct premium in your premium calculation. Please note that Worldwide Coverage Excluding the United States and Canada excludes any expenses incurred in the United States and Canada. After you have made a selection, please keep in mind that you may not alter your coverage location option.

2. Please Choose Your Policy Period Medical Deductible: \$250 \$500 \$1,000 \$2,500 \$5,000

3. Would you like to include the Dental Option: Yes No

4. Would you like to include the Sports Option: Yes No

5. Would you like to include the Hospital Daily Indemnity Option: Yes No

6. 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.

If the Insured Person chooses Worldwide Coverage including the United States and Canada, they must leave the U.S. within 30 days of the Effective Date for coverage with Lloyd's; for Tramont the Insured Person may not be in the U.S. at the time of application or on the Effective Date. If the Insured Person chooses Worldwide Coverage excluding the United States and Canada, they must leave the U.S. prior to the effective date for both Lloyd's and Tramont. In addition, for Tramont, they may not be in the U.S. at the time of application. 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				

Address of Residence:

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Phone: (____) _____ Business Phone: (____) _____ Fax: (____) _____
(please include area and/or country code)

Email: _____

Occupation of Primary Insured: _____
(If retired, previous occupation(s))

Name of Employer: _____

Duties of Occupation: _____

Occupation of Spouse: _____

Family Physician Name: (Required) _____

Physician Name who performed your last physical: _____
(If different from Family Physician)

yes no

- 1. Do you understand this is an international program and not U.S. health insurance?
- 2. Do you understand that you are unable to be in the U.S. longer than 180 days during any given 364-day period?
- 3. Are you or any listed dependents currently in the United States? If yes, enter departure date below.
When do you plan to depart the United States: ____ / ____ / ____ *(month/day/year)*
- 4. Are any listed dependents who are age 19, 20, 21, 22 and 23 full-time students? *(if yes, please list schools and locations)*

- 5. Do you understand that the Extended Coverage Benefit Schedule will begin after you have been covered continuously for three Policy Periods? On the first day of the fourth Policy Period, the Extended Coverage Benefit Schedule will begin.

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, been diagnosed with, or are you or any applicant 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, gastroesophageal reflux disease (acid reflux, GERD), hemorrhoids, colon or rectum disorders)?
- 2. Cardiovascular and/or circulatory diseases or disorders (including, but not limited to: high or low blood pressure, elevated cholesterol, heart attack, angina, chest pains, arteriosclerosis, coronary insufficiency, thrombosis, phlebitis, vascular afflictions, rheumatic fever, heart murmur, shunts, stents, pacemaker)? 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, bronchitis, tuberculosis, lung disorders, emphysema, respiratory insufficiency, pleurisy, pneumonia, sleep apnea)?
- 4. Asthma or allergies?
 - a) Hospitalization or emergency room treatment? Yes No
If yes, how many in last year and date of last incident? _____
 - b) Medications: Type: _____ Dosage: _____
 - c) Frequency of attacks _____
- 5. Diseases or disorders of the eyes, nose, ears, mouth, throat or jaw (including, but not limited to: nasal septum deviation, sinusitis, cataracts, glaucoma, ear infections, TMJ)?
- 6. Sexually transmitted diseases or immune deficiency disorder (AIDS / ARC), tested positive for HIV or any related illness?
- 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 No
 - e) Date of last HbA1c Test: _____ / _____ / _____ (MM/DD/YYYY) HbA1c Results (1-10): _____
- 8. Diseases or disorders of the pancreas, liver, gallbladder or endocrine disorders (including, but not limited to: obesity, pituitary or lymph glands, thyroid or metabolic disorders)?
- 9. Blood, sugar, and/or protein in urine?
- 10. 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, autism, obsessive compulsive disorder, attention deficit disorder, adult attention deficit disorder)?
- 11. 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?
- 12. Have you or any applicant used an illegal drug, had any diagnosis or treatment of an alcohol, chemical or drug dependency, problem or abuse, or been advised to reduce alcohol intake, or had any alcohol, chemical or drug related criminal conviction, moving traffic violation, or driver’s license suspension?
- 13. Kidney or urinary tract system diseases or disorders (including, but not limited to: kidney or bladder stones and infections)?
- 14. Cell or blood diseases or disorders (including, but not limited to: cancer, tumors, cysts, polyps or other growths of the internal organs, hepatitis, leukemia, anemia, or Kaposi’s sarcoma)?
- 15. Diseases or disorders of the skin (including but not limited to: psoriasis, skin cancer, acne, eczema)?
- 16. Muscular or skeletal diseases or disorders and inflammation (including, but not limited to: scoliosis, arthritis, rheumatism, gout, tendonitis, joint or vertebrae disorders, osteoporosis, fibromyalgia, amputation)?
- 17. Diseases or disorders of the breasts (including, but not limited to: cysts, nodules, calcifications or abnormal mammogram)?
- 18. 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)?
 - a) If you answered yes to this question, please indicate if you had any abnormal results or were advised to undergo further testing, surgery, or treatment? If yes, please provide detail in section 4.
- 19. For male applicants, diseases or disorders of the reproductive system (including, but not limited to: prostate or elevated PSA level)?
- 20. For female applicants, diseases or disorders of the reproductive system (including, but not limited to: vaginal bleeding, fibroids, nodules, fallopian tubes, ovaries or uterus)?

section 3. underwriting questions for all applicants (continued)

yes no

- 21. For female applicants, are you currently pregnant or have you had a complicated pregnancy or delivery? If currently pregnant, when is the expected due date? ____ / ____ / ____ (MM/DD/YYYY)
- 22. In the last 12 months, have you or any applicant used any form of tobacco?
If "Yes" what form of tobacco? _____ Who uses? _____ How often: _____
- 23. Have you or any applicant had or been recommended to have, or are you currently on a waiting list for an organ transplant?
- 24. Have you or any applicant consumed alcoholic beverages in excess of 14 drinks per week? If yes, specify type and how much per week (one drink equals 12 oz. of beer, 4 oz. of wine, 1 oz. of hard liquor). _____
- 25. In the last 12 months, have you or any applicant experienced a weight gain or loss of 15 pounds or more?
- 26. Any Congenital defect, physical disorder or deformity, or developmental problems not listed above?
- 27. Are you or any applicant currently hospitalized or scheduled for or in need of hospitalization or surgery, disabled or unable to perform normal activities?
- 28. 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, Medication Prescribed and Results of Treatment	Duration / Dates of Treatment	Physician / Clinic Address and Telephone #

Information about prior / other coverage

yes no

- 1. Have you or any applicant ever applied for or purchased insurance through Seven Corners?
Name _____ Policy/Certificate Number _____
- 2. Have you been covered by another medical plan at any time during the past year?
- 3. Have you or any applicant ever been rejected, ridered, cancelled, had coverage rescinded, or had premium increased for any Health, Life or Disability Policy?

4. Will you be covered under any other medical plan (*individual or group*) while you are covered under this plan?
For all "YES" answers to questions 2 through 4, please provide the following information. If more than one situation applies, attach a separate piece of paper to describe each situation.

Name of Insured(s): _____

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 Prime program and for the insurance provided by 1) Certain Underwriters at Lloyd's of London (the "Underwriter") for which 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 and 2) Tramont Insurance Company Limited (the "Underwriter") for which I hereby enroll in the group coverage for which I am eligible under the group contract issued by Tramont Insurance Company Limited.

I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto are 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, or for a condition that with reasonable medical certainty existed before his or her effective date, according to the pre-existing conditions 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, the 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 180 days during any given 364-day period. I also understand that treatment incurred in the United States and Canada will not be covered if I have selected and purchased coverage for Geographical Treatment Area B (worldwide coverage excluding the United States and Canada).

I also understand that Lloyd's of London operates as a surplus lines insurer in most U.S. states (except Kentucky and Illinois where Lloyd's is an admitted insurer), and Tramont Insurance Company Limited operates as an authorized insurer worldwide (coverage on Tramont cannot be initiated and purchased in the British Virgin Islands, U.S. Virgin Islands, and the United States, although coverage is provided in these areas per the plan requirements). Claims may not be made against a state guarantee insurance fund for either insurance carrier. 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 law or regulation 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. This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include any additional benefits required by the PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances, penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent, or tax professional to determine if the PPACA's requirements are applicable to you.

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

section 6. premium and payment information

Premium is due with the submission of the application.

1. Standard Medical Plan:	2. Additional AD&D Rider <small>(see Section 1 details):</small>	3. Dental Rider:	4. Sports Rider:	5. Hospital Daily Indemnity Rider:	6. TOTAL:
Policy Period Premium for each family member from the Premium table.	Policy Period Premium for each family member depending upon Principal Sum selected.	Policy Period Premium for each family member <i>(if selected for one, then all applicants must purchase the option).</i>	Policy Period Premium for each family member <i>(if selected for one, then all applicants must purchase the option).</i>	Policy Period Premium for each family member <i>(if selected for one, then all applicants must purchase the option).</i>	Add the Premium amounts for each column chosen. Medical is required, the others are optional.
Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____
Subtotal A: \$ _____	Subtotal B: \$ _____	Subtotal C: \$ _____	Subtotal D: \$ _____	Subtotal E: \$ _____	Total F: \$ _____

	x		=	
Policy Period Premium for all applicants from TOTAL F		Installment Factor (see below)		Total Initial Payment

Installment Factor:

- One Payment in Full = 1.00
 Two Payments = 0.55
 Four Payments = 0.28
 Twelve Payments = 0.10

Important: Checks and Money Orders accepted for Annual Premium only from U.S. banks

method of payment

- Check
 Money Order
 Visa®
 MasterCard®
 Discover®/Novus®
 American Express®
 Diners Club International®

Card Number: Expiration Date: ____/____ (month/year)
CVV: _____

Name as it appears on the Card: _____

Daytime Phone: (____) _____ Alternate Phone Number: (____) _____

Signature (Required): _____

Billing Address: _____ City/State/Zip: _____

All premium payments must be made in U.S. dollars. Checks must be issued from a U.S. bank and made payable to "Seven Corners." If paying by credit card, I authorize Seven Corners to debit my credit card account for the total amount due. In the event that I have elected to *Pre-Authorize credit card payment installments, I hereby request and authorize Seven Corners to debit my credit card periodically as payment installments become due. This authorization will remain in effect until revoked by me in writing and until Seven Corners actually receives notice. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. *For any installment payment other than once per Policy Period, I pre-authorize Seven Corners to debit my credit card for the proper installment amount on the due date of the installment. **Check or money order should be made payable to Seven Corners. All payments must be made in U.S. dollars, from a U.S. bank, and submitted at the time application for coverage is made.**

agent information

Agent Name: _____ Seven Corners Agent #: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

Agent Certification: I am not aware of any other information that may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this application nor any supplement to the application. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the application and the answers recorded to confirm completeness and accuracy.

Signature of Agent _____

Date _____

Security: Certain Underwriters at Lloyd's of London or Tramount Insurance Company Limited.

Please mail or fax to:

Important Information

It is important to note that Reside Prime is a program for international citizens, and Lloyd's of London and Tramount Insurance Company Limited are international insurance entities. Lloyd's of London operates as a surplus lines insurer in most U.S. states. Tramount Insurance Company Limited operates as an authorized insurer worldwide (coverage cannot be initiated and purchased in the British Virgin Islands, U.S. Virgin Islands, and the United States, although coverage is provided in these areas per the plan provisions). Coverage and benefits under Reside Prime are not regulated by any U.S. state insurance department.

The information concerning Reside Prime is not intended to be an offer to sell Reside Prime or a solicitation by Seven Corners, Inc. or Lloyd's of London, or Tramount Insurance Company Limited in any jurisdiction where such an action would be unlawful or in which Seven Corners, Lloyd's of London, or Tramount Insurance Company Limited is not qualified to do so. Reside Prime may not be available in all situations or jurisdictions. Reside Prime is intended for persons living or traveling outside the United States.