

reside® worldwide medical plan

Worldwide Rates Including U.S. and Canada (Geographical Treatment Area A)

Premiums Effective April 1, 2012

Age	Policy Period Premium \$70 Per Incident Deductible	Policy Period Premium \$100 Per Incident Deductible	Policy Period Premium \$150 Per Incident Deductible	Policy Period Premium \$250 Per Incident Deductible	Policy Period Premium \$500 Per Incident Deductible	Policy Period Premium \$1000 Per Incident Deductible
14 days through 18	US \$596	US \$541	US \$519	US \$487	US \$433	US \$379
19 through 29	US \$627	US \$570	US \$547	US \$513	US \$455	US \$399
30 through 39	US \$909	US \$763	US \$733	US \$688	US \$611	US \$535
40 through 49	US \$1,085	US \$987	US \$947	US \$888	US \$789	US \$691
50 through 59	US \$1,213	US \$1,103	US \$1,059	US \$993	US \$882	US \$772
60 through 69	US \$2,258	US \$2,053	US \$1,970	US \$1,847	US \$1,642	US \$1,437
70 through 74	US \$3,270	US \$2,973	US \$2,855	US \$2,676	US \$2,378	US \$2,081

Worldwide Rates Excluding U.S. and Canada (Geographical Treatment Area B)

Premiums Effective April 1, 2012

Age	Policy Period Premium \$70 Per Incident Deductible	Policy Period Premium \$100 Per Incident Deductible	Policy Period Premium \$150 Per Incident Deductible	Policy Period Premium \$250 Per Incident Deductible	Policy Period Premium \$500 Per Incident Deductible	Policy Period Premium \$1000 Per Incident Deductible
14 days through 18	US \$487	US \$443	US \$425	US \$398	US \$354	US \$310
19 through 29	US \$513	US \$466	US \$447	US \$419	US \$373	US \$327
30 through 39	US \$744	US \$624	US \$600	US \$563	US \$500	US \$438
40 through 49	US \$888	US \$807	US \$775	US \$727	US \$646	US \$565
50 through 59	US \$993	US \$903	US \$867	US \$813	US \$722	US \$632
60 through 69	US \$1,848	US \$1,679	US \$1,612	US \$1,511	US \$1,344	US \$1,175
70 through 74	US \$2,676	US \$2,433	US \$2,336	US \$2,190	US \$1,946	US \$1,703

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 insurer in most U.S. 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® worldwide application for coverage

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

As described in the brochure and documentation, Reside Worldwide 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.

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” was marked must be described in detail in Section 3. Information 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 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 only 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. Once Seven Corners reviews your application and determines that coverage should be issued, we will send you 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 concerning procedures for claims submission and the importance of Seven Corners’ pre-notification procedures.

All Sections Must Be Completed in Full

section 1. applicant information:

Applicant’s Name <i>(First, Middle, Last, Maiden)</i>	Sex <i>M/F</i>	Relationship	Date of Birth <i>(Mo/Day/Yr)</i>	Citizenship <i>Country</i>	Height <i>Feet / Inches</i>	Weight <i>lbs</i>	Premium
		Primary					
		Spouse					
		Child					
		Child					
		Child					

Total Premium:

Address of Residence:

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____ E-mail: _____

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

(If your residence address is outside of the United States, policy fulfillment will be provided electronically. Please contact Seven Corners for any questions.)

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

Name of Employer: _____

Duties of Occupation: _____

Occupation of Spouse: _____

Family Physician Name: (Required) _____

Address or contact info of Family Physician: _____

Physician Name who performed your last physical: _____

(If different from Family Physician)

Address or contact info of physician who performed your last physical: _____

reside® worldwide application for coverage

section 1. (continued) applicant information:

(Please all that apply and state in detail in Section 3. Health History Detailed Answers)

Yes No

- 1. Do you understand this is an international program and not U.S. health insurance?
- 2. Do you understand that if you are a U.S. Citizen you are unable to be in the U.S. longer than 180 days during any given 364 day period?
- 3. If you are a non-U.S. Citizen do you require coverage for more than 180 days in the United States?
Please enter length of time and how long you require coverage below.
Length of time per year inside the United States: _____
How long do you require coverage under Reside? _____
- 4. 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)
- 5. Are any listed dependents who are age 19, 20, 21, 22 and 23 full time students?
(if yes, please provide proof of student information, must be enrolled in at least 12 credit hours of study)
- 6. Have you completed the required physician contact information? If not, please do so.

section 2. health history questions for applicants

(Please all that apply and state in detail in Section 3. Health History Detailed Answers)

In order for your Application to be processed successfully, each question must be answered truthfully for all applicants.

Yes No

- 1. Are you or any proposed insured currently pregnant, or if insuring dependents are you an expectant father or planning on adopting?
- 2. Within the last five (5) years have you or any proposed insured been hospitalized?
- 3. Within the last five (5) years have you or any proposed insured received medication, been diagnosed as having or been treated by any medical professional for any of the following conditions: liver disorder; cancer (excluding basal cell carcinoma); heart or circulatory system disorder including heart attack, stroke or cardiomyopathy (but not including hypertension); diabetes; nervous system disorder including muscular dystrophy; immune system disorder including AIDS Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV); or been hospitalized for mental or nervous disorder, alcohol use or drug use?
- 4. Are you or any applicant currently hospitalized or scheduled for or in need of hospitalization or surgery, disabled or unable to perform normal activities?
- 5. 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?
- 6. Do you take any medications? If so, please provide a list of current medications for each applicant.

section 3. health history detailed answers

Please provide detailed answers to questions posed above.

Question Number	Answer

reside® worldwide application for coverage

section 4. declaration and enrollment request / authorization to release medical information

I hereby apply for the Reside Worldwide 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 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 characteristic(s). This authorization includes information about drugs, alcohol use, 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 if I am a United States citizen, coverage in the United States is limited to 180 days during any given 364-day period. I understand that if I am a non-United States citizen, coverage in the United States is limited to 180 days during any given 364-day period if I have not provided a Proof of Eligibility Form. If I have provided a Proof of Eligibility Form, I am limited to 4 consecutive Policy Periods in the United States. 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). Thus, claims may not be made against any state guarantee 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 5. program specifics

Please choose a deductible: \$70 \$100 \$150 \$250 \$500 \$1,000

Requested Effective Date: ____ / ____ / ____ (month/day/year) *Requested Effective Date must be within 60 days of application date. If you choose Worldwide Coverage excluding the U.S. and Canada, you must leave the U.S. prior to the Effective Date. In addition, for Tramont, you 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, the Primary Insured shall be the beneficiary of the certificate. If the benefit is utilized for the Primary Insured, his/her estate shall be the beneficiary. If this is not acceptable, please list the beneficiary:

Beneficiary

