

reside® worldwide application for coverage

2007 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 in Section 3 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 only 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. Once 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 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: *(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: (____) _____ E-mail: _____

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: _____

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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 6 months during any given 12-month period?
- 3. If you are a non-U.S. Citizen do you require coverage for more than 6 months 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 above? 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 hospital confined for four (4) consecutive days or longer?
- 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, alcoholism or drug abuse (including dependence or addiction)?

section 3. health history detailed answers

Please provide detailed answers to questions posed above.

Question Number	Answer

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 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 if I am a United States citizen, 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 any state guarantee fund. I UNDERSTAND and AGREE that this program is issued outside the United States and that the program does not comply with any U.S. state insurance law.

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

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 and insured person must leave the U.S. within 30 days of the Effective Date. If accepted, official Effective Date will be advised by Seven Corners, Inc.)

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

