Life and Health Insurance Company

APPLICATION

PAYMENT FORM

◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly ◯ Check ◯ Credit Card ◯ Wire Transfer

PLANS/ COVERAGES

◯ Sky ◯ Sun ◯ Star ◯ $1,000,000 ◯ $2,000,000 (Optional Sky) Deductible: $________________

1. APPLICANT INFORMATION

	NAME(S)	LAST NAME(S)	Relation	Sex	Date of Birth			Age	Height mts. / feet	Weight lbs. / kgs.	Nationality	PREMIEUM
					day	month	year					
1			Primary Insured									
2												
3												
4												
5												
6												
7												
8												
9												

FILING STATUS (Main Insured) ◯ Married ◯ Single ◯ Divorced ◯ Widowed

INCLUDE COPY OF PICTURE ID OF THE MAIN INSURED

If spouse and/ or children are not included in the application, explain why:

2. OPTIONAL SUPPLEMENTS

◯ Single Mother Maternity $300

◯ Student in the United States $375

3. PREMIUMS

ANNUAL PREMIUM		PREMIUM FACTOR		ADMINISTRATIVE COST		TOTAL PREMIUM
$	x	Semi-Annual: x 0.55 Quarterly: x 0.28 Monthly: x 0.10	+	$ 100.00	=	$

4. PERMANENT RESIDENCE ADDRESS *(Cannot be a United States Address)*

Address:

City: | Country: | Tel: | Cell: | e-mail:

5. MAILING ADDRESS *(If Other)*

Address:

City: | Country: | Tel: | Cell: | e-mail:

6. EMPLOYER'S NAME AND ADDRESS

Employer: | Nature of Business:

Address:

City: | Country: | Tel: | Fax: | e-mail:

7. OCCUPATION AND DUTIES

Main Insured: | Title:

List Specific Duties:

Spouse: | Title:

List Specific Duties:

8. UNDERWRITING QUESTIONS FOR ALL APPLICANTS:

In order for your application to be processed successfully, each question must be answer truthfully. Any "YES" answered must be clarified in Section #9: Health History Details. Attach any additional information and medical reports for the corresponding questions.

All questions must be answered and sufficient medical data must be reported in order for the Administrator to underwrite the application.

Applicants over the age of 59 must submit an attending physician statement (APS).

Within the past ten (10) years, have you or any of the applicants been medically advised, referred, counseled, treated, had surgery or been treated, diagnosed or taken prescription medication for any of the following?

	YES	NO
1. Cardiovascular and/ or circulatory diseases disorders or hypertension.	◯	◯
2. Cell or blood related diseases or disorders, benign, malignant tumors or cancer.	◯	◯
3. Muscular or skeletal diseases or disorders, backache, rheumatism.	◯	◯
4. Digestive system diseases or disorders, esophagus, stomach, intestine, pancreas, kidneys, gall bladder.	◯	◯
5. Diseases or disorders of neurological and nervous system, migraine.	◯	◯
6. Kidney disorders or diseases or in the urinary track system.	◯	◯
7. Pulmonary or respiratory diseases or disorders, asthma, allergies.	◯	◯
8. Eyes, nose, ears, throat disorders, or diseases.	◯	◯
9. Any congenital, genetic or hereditary condition, diseases or disorder, deformity or development problem.	◯	◯
10. Any addictive or mental diseases or disorders.	◯	◯
11. Hormonal or endocrine diseases or disorders.	◯	◯
12. Diabetes a.) Type ____I Type ____II b.) Date Diagnosed c.) Medications: _____________ Dosage _______	◯	◯
13. Sexually transmitted diseases or immune deficiency disorder or AIDS/HIV.	◯	◯
14. Any type of skin disease or disorder.	◯	◯

	YES	NO
15. Cosmetic Surgeries, oral surgery, dental condition, or weight loss treatment.	◯	◯
16. Any other disease or disorder.	◯	◯
17. Have you been advised or any applicant to have any diagnostic test, under gone special testing (x-rays, electrocardiogram, radiology or any blood work)	◯	◯
18. Have you or any applicant been advised for the need or have been hospitalized, consulted a thera pist or physician, had surgery or exists any reason why you should visit the doctor	◯	◯
19. Have been advised to or are taking any prescription drug or is there any reason you should be.	◯	◯
20. Are you currently hospitalized or suffering from any disease, or incapacitated from performing normal activities.	◯	◯
21. In the past twelve(12) months have experienced any symptom, have diagnosed or treated for any reason that will lead you think that you might experience a new medical condition	◯	◯
22. In the Past twelve(12) months have used any form of tobacco? Quantity____ How Often____	◯	◯
23. For MALE applicants: disease or disorders of the reproductive system or prostate.	◯	◯
24. For FEMALE applicants: a.) Diseases or disorders of the reproductive system b.) Are you currently pregnant Expected Due Date __/__/__ c.) Have or had complicated pregnancies or deliveries d.) Have you been submitted to any fertility treatment	◯	◯

9. HEALTH HISTORY DETAILS

Give full details for each applicant on YES answers in section 8, Underwriting questions (use addtitional paper and attach medical reports for corresponding questions if necessary). Incomplete answers may delay processing.

	NAME	QUESTION#	Condition, diagnosis, treatment, medication prescribed and results of treatment	Date seen and Durration	Physician Hospital Address & Phone #
1					
2					
3					
4					
5					
6					

10. PROVIDE NAME, ADDRESS AND PHONE NUMBER OF APPLICANT(S) FAMILY PHYSICIAN OR PHYSICIAN WHO PERFORMED LAST ROUTINE PHYSICAL.

(Without this information, this application will not be processed)

Name of physician:		Last Date:
City/ Country:	Phone:	Fax:
(Spouse) name of Physician::		Last Date:
City/ Country:	Phone:	Fax:
(Kids) Name of Physician:		Last Date:
City/ Country:	Phone:	Fax:

11. LIST OF ELIGIBLE DEPENDENT FULL TIME STUDENTS (Between the ages 18 and 23) Proof of student status is required.

	STUDENT NAME	COLLEGE/ UNIVERSITY-LOCATION
1		
2		

12. WILL ANY APPLICANTS RESIDE OR TRAVEL TO THE UNITED STATES FOP MORE THAN SIX(6) MONTHS, DURING ANY POLICY PERIOD

○ YES ○ NO

NAME	EXPECTED DATE

13. PRIOR OR CURRENT HEALTH INSURANCE COVERAGE

List all current health insurance coverage:

A. Local Health Coverage:

Insurance Company:____

Policy #____________________________ Effective Date:_______/_______/_________ Termination Date:_______/_______/_________
day month year day month year

B. International Health Coverage:

Insurance Company:____

Policy #________________________ Effective Date:_______/_______/_________ Effective Date:_______/_______/_________
day month year day month year

** Enclose a copy of your insurance certificate or policy and the last payment receipt.*

C. Have you or any applicant been declined, applied an execlusion, or had a rate up in premium with any other health disability or life policy?

○ YES ○ NO

D. Has any claim been presented for coverage of benefits under any insurance policy by yourself or any of the proposed insured?

○ YES ○ NO

Give details to affirmative answers: ____

14. DECLARATION AND ENROLLMENT REQUEST/ AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I CERTIFY that I have read and reviewed the completed application and all the answers and statements I provided on this Application and any attachment hereto is complete truthful to the best of my knowledge and belief. I understand that the Administrator, Global Assurance Group, and Claria Life and Health Insurance Company, will rely on all information on this Application in determining whether or not to issue coverage and that any omissions, incorrect or incomplete information could cause claims to be denied and the policy to be modified, cancelled or rescinded at any time upon discovery.

I UNDERSTAND that this application seeks full disclosure of the information sought and no one has the authorization to alter or exclude any qualification information sought in this application.

I UNDERSTAND that health benefits may be limited or excluded for conditions which any insured person has received any medical diagnosis or treatment, or taken any medication, before his or her effective date, according to pre-existing conditions limitations provisions of the plan. If any person requires medical care or treatment after the application for insurance is signed, not before the effective date of this policy, full details must be provided to the insurer for final approval before coverage is effective. I agree to accept the policy with the terms and conditions as issued, otherwise I will notify my disagreement in writing to the company within the first ten (10) days of receipt of the insurance policy.

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, employer or any individual having any information about me or my dependents listed on this application to disclose to Global Assurance Group and Claria Life and Health Insurance Company, or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to any information about: 1.) physical condition(s), 2.) health history(ies), 3.) advocations, 4.) age(s), 5.) occupation(s), and 6.) personal characteristics. This authorization includes information about: 1.)drugs, 2.) alcoholism, 3.)mental illness, or communication diseases. A photocopy of this application shall be valid as the original. This authorization shall remain valid as long as any insurance is in force.

I UNDERSTAND that the information obtained by use of this Authorization will be used by Global Assurance Group and Claria Life and Health Insurance Company to determine eligibility for benefits.

I ALSO AUTHORIZE, Global Assurance Group and Claria Life and Health Insurance Company 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 a may be otherwise lawfully required, or as I may further authorize.

I AGREE that the rules of Claria International Health Plans will be binding on me and all eligible dependents included in my policy. You are advised to keep record of all information you supply to us in connection with this application, including letters. If you would like a copy of this form, please inform us.

I UNDERSTAND that as resident of a foreign jurisdiction, I may be subject to foreign laws with the respect to the type and form of the coverage in which I am enrolling.

I ALSO UNDERSTAND that the policy will become effective in accordance with the terms of the effective date and the acceptance of, Global Assurance Group, and Claria Life and Health Insurance Company. I understand that no coverage is in effect until I am notified in writing by Global Assurance Group and Claria Life and Health Insurance Company and advised of the official Effective Date. I also understand that if I am not accepted for coverage by Global Assurance Group and Claria Life and Health Insurance Company, it is the sole obligation of Global Assurance Group, and Claria Life and Health Insurance Company to return the premium paid.

I UNDERSTAND that this coverage is not, nor does intend to be a United States health insurance policy. I understand that the coverage in the United States is limited to six (6) months out of the twelve (12) months policy period covers and if I or any applicant spends more than the allotted six(6) months in the United States this coverage will be voided and all claims will not be paid.

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 application or enrollment form, or files a claim containing a false deceptive statement, may be guilty of insurance fraud.

______________________________ SIGNATURE OF THE PROPOSED INSURED OR GUARDIAN

______________________________ SIGNATURE OF PROPOSED INSURED'S SPOUSE

Complete Name:______________________________ *(PLEASE PRINT)*

Complete Name:______________________________ *(PLEASE PRINT)*

Signed on ___________ of ______________, 20_______, in the city of ________________________ , (Country) ________________________

THIS APPLICATION CANNOT BE SIGNED IN THE UNITED STATES

15. AGENT INFORMATION (FOR AGENT USE ONLY)

Agent Certification: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and I have not altered any responses recorded on this application or any supplement to it. I have not advised the applicant(s) to withhold any information related to the answers to the questions and I have advised the applicant(s) to review the application and the answers recorded to confirm their completeness and accuracy.

Agent Code:	Signature of Agent:
Name of Agent:	
Code and Name of the Agent:	
Code and Name of the General Agency:	