GLOBAL BENEFITS GROUP

Insurance Without Borders©

Individual Application Form

Health / Life / Disability

Form to be completed by Life Assured – Please print clearly and COMPLETE ALL QUESTIONS.

Section 1. Applicant Details

1. Title: (Mr/Mrs/Ms/Other)	2. Surname:	3. Forenames:

4. Gender:		5. Date of Birth (mm/dd/yy):	6. Height:	7. Weight:
☐ Male	☐ Female		m / feet	lbs / kgs

8. Marital Status:	9. Home Country:
☐ Married ☐ Divorced ☐ Single ☐ Other: ______	

10. Nationality:	11. Country of Residence:	12. Annual Salary: (US$)

13. Occupation: (Please provide full description)	14. Employer's Name and Address

15. Social Security Number (If any):

Country A: ______________ Number: ______________

Country B: ______________ Number: ______________

16. Are you entitled to any Social Security or Government plan in the Country of Residence? (If yes, please provide full details):

☐ YES ☐ NO

17. Are you entitled to any reimbursement from another Insurer? (If yes, please provide full details):

☐ YES ☐ NO

18. Details of Principal Residence:

Mailing Address: ______________

____

____

Country: ______________

Postal Code: ______________

Contact Details:

Home Tel. No.: ______________

Mobile Tel No.: ______________

Fax No.: ______________

Email Address: ______________

19. Anticipated travel patterns for the next 12 months:

Destinations: ______________

____

____

Frequency: ______________

____

Duration: ______________

____

Duties: ______________

____

____

20. Spouse

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

20. Dependent

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

20. Dependent

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

20. Dependent

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

20. Dependent

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

20. Dependent

Last Name: ____________________

First Name: ____________________

Date of Birth: Month:_____ Day:_____ Year:_____

Male: ☐ Female: ☐

Relationship to Primary Applicant: ____________________

Height: _____ Weight:_____ Nationality: _____

Citizenship: ____________________

Occupation: ____________________

Country of Residence: ____________________

MEDICAL INSURANCE POLICY SELECTION:

Check One: ☐ Worldwide (No Area Exclusions) ☐ International (No Coverage U.S. or Canada) ☐ International Plus (Emergency Coverage in Restricted Areas)

Requested Effective Date: ________________ Coverage Type: ☐ Single ☐ Married ☐ Single Parent Family ☐ Family

Annual Deductible: (circle one) $100 $250 $500 $1000 Other _______

Co Payment: ___ 100% outside North America ___10% inside North America in Network

___20% inside North America in Network ___30% inside North America in Network

Preferred Method of Payment: Under $5,000 Premium Only Over $5,000 Premium Only

☐ Semi Annual (add 5% surcharge) ☐ Quarterly (add 5% surcharge) ☐ Monthly (add 5% surcharge)

Please tick (✓) cover required Currency of benefits:	☐ US Dollar ($) ☐ British Pound (£) ☐ Euro (€)
1. ☐ LIFE INSURANCE	Sum Assured: ________________
2. ☐ LONG TERM DISABILITY INSURANCE	Benefit (% Salary): ___ % per month with escalation of ☐ 0% ☐ 3% per annum ☐ 5% per annum Deferred Period (weeks) ☐ 13 ☐ 26 ☐ 52
3. ☐ SHORT TERM DISABILITY INSURANCE	Benefit (% Salary): __________ per month Deferred Period (weeks) __________
4. ☐ ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE	Sum Assured: ________________
5. ☐ WAR & TERRORISM EXTENSION	An extension for War & Terrorism Coverage (excluding NCB Perils) can be added to the above benefits, but is subject to Underwriters' approval and additional premium loading.
6. ☐ NCB PERILS EXTENSION	An extension for Nuclear, Chemical and Biological Perils can be added to the above benefits, but is subject to Underwriters' approval and additional premium loading.
Requested Effective Date: (dd/mm/yy)	

TRAVEL PATTERN
Please advise below your anticipated travel pattern for the next 12 months including destinations, frequency of travel, duration of travel, and duties whilst travelling.
If you are applying for the War & Terrorism / NCB extension(s), please provide details of the security arrangements in place.

Continue to the next page

Section 2. Medical Questionnaire (Part A)

If your answer is "Yes" to any of the following six questions please answer additional questions, otherwise please move on to next question.

1) Does your state of health prevent you from performing your activity at full time?	Yes	No

If yes, please answer following additional questions:

a) Partial or total sick leave:

b) Reasons of sick leave:

2) Have you suffered in the last 10 years from a disease or an accident entailing 30 days or more sick leave and/or medical treatment?	Yes	No

If yes, please answer following additional questions:

a) Cause and length of sick leave:

b) Date of sick leave:

3) Did you or are you planning to undergo a surgical operation?	Yes	No

If yes, please answer following additional questions:

a) Which one?

b) When?

4) Do you suffer from any disabling illness, physical defect, infirmity or congenital illness or from the consequences of an illness or accident?	Yes	No

If yes, please answer following additional questions:

a) Which disablement?

b) Which ones?

c) Date of accident?

d) Wounds?

5) Are you currently pregnant?	Yes	No

If yes, please answer the following question:

a) What is your expected due date?

6) Do you receive any disability pension or work accident pension?	Yes	No

If yes, please answer following additional questions:

a) Why?

Section 2. Medical Questionnaire (Part B)

Have you, or your eligible dependent been advised, counselled, tested, diagnosed, treated, hospitalized, or recommended for treatment within the last 10 years for the following: (If you answer "Yes" to any question, please circle the condition to which you are referring and give complete details in Part C.)		
1) Seizures or seizure disorder; paralysis; multiple sclerosis; or any disorder of the central nervous system?	Yes	No
2) Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psycho-therapy; psychological, marital or any form of counselling or therapy?	Yes	No
3) High blood pressure; heart attack; stroke; chest pain or palpitations; murmur; varicose veins, blood clot, anaemia, or any other blood, heart, or circulatory disorder or condition?	Yes	No
4) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	Yes	No
5) Colitis; chronic diarrhoea or intestinal problems; hernia; ulcer of the stomach or duodenum; haemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, oesophagus, or any other digestive disorder or condition?	Yes	No
6) Cancer, tumour, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth, or any other skin disorder?	Yes	No
7) Disease or disorder of the breast; kidney; kidney stones; bladder; prostrate; abnormal PSA, or any other urinary disorder or infection?	Yes	No
8) Disease or disorder of the genital or reproductive system; herpes, any sexually disease; endometriosis, or abnormal pap smear?	Yes	No
9) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	Yes	No
10) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement; or chiropractic treatment?	Yes	No
11) Pituitary, adrenal, or thyroid disorder; lupus; diabetes?	Yes	No
12) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear nose, or throat disorder?	Yes	No
13) Alcoholism; alcohol, drug or substance abuse or dependency?	Yes	No
14) Acquired immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	Yes	No
15) Have any parents, children, or siblings suffered from cancer, diabetes, hyperlipedemia, chronic mental diseases before 50 years of age?	Yes	No
16) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	Yes	No
17) Have you smoked cigarettes or used tobacco in any form in the past 12 months?	Yes	No
18) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	Yes	No
19) Have you been hospitalized in the last 10 years for any reason?	Yes	No
20) Do you engage in any profession, sport, or hobby that could be considered hazardous?	Yes	No
21) During the past 3 years, has any illness or injury prevented you from work?	Yes	No
22) During the past 5 years, have you consulted or been advised to consult a medical practitioner for any significant physical impairment, deformity sickness, operation, injury, or hospitalization other than revealed in questions above?	Yes	No

Section 2. Medical Questionnaire (Part C)

Give details of each item answered "Yes" in Part B.
(If more space is needed, attach separate page, which must be signed and dated)

Name	Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates from/to	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

Section 3. Medical Practitioner

Please provide details of your family Doctor(s), if you have one:

Details of Current Family Doctor:

Name: ____________________

Mailing Address: ____________________

____

____

____

Email: ____________________

Telephone No.: ____________________

Details of Previous Family Doctor, if changed within past 5 years:

Name: ____________________

Mailing Address: ____________________

____

____

____

Email: ____________________

Telephone No.: ____________________

Section 4. Beneficiary Information (Applicable for Life Cover Only)

Please provide details of the beneficiary for any Life Insurance Benefit:

Is Beneficiary an Individual(s) or an Entity: ☐ Individual(s) ☐ Entity (Trust, Estate, Corporation or Partnership)

Name: ____________________ Telephone No.: ____________________

Mailing Address: ____________________

____

____

Section 5. Representations, Acknowledgements, and Authorizations

I, the Life to be assured, and (if different) the Grantee, declare that to the best of my knowledge and belief all the statements made in this proposal are true and complete. I undertake to inform the Underwriters of any changes to these statements which occur before the contract completes and I understand that failure to do so may affect the validity of the contract.

Failure to disclose any material facts known to me may invalidate the contract. (A material fact is one that is likely to influence the Underwriters' acceptance or assessment of your proposal. You should consult your insurance adviser if in any doubt as to what may be a material fact.)

I, the Life to be assured consent to the Underwriters seeking medical information from any doctor who has attended me concerning anything which affects my physical or mental health or seeking information from any Insurer to whom a proposal has been made for assurance on my life and I, authorise the giving of such information.

I hereby declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days in the preceding twelve months.

I agree that there shall be no insurance until this application has been accepted by the Insurer, and the first full premium has been paid, and that payment has been effectively received by the Insurer.

Signature of Assured: **Date Signed:**	

EXPEDITING YOUR APPLICATION

We cannot accept your application if this Health Declaration is incomplete. Should we need to contact you rapidly regarding the Health Declaration, please circle your preferred method and provide details:

Telephone / Private E-Mail / Other: ______________________________

Please use additional space below for any long answers you may have or additional information you may think is necessary:

GLOBAL BENEFITS GROUP

Insurance Without Borders©

Residence Verification Form

By signing this *Residence Verification Form*, I, ____________________, certify that **I am not** a resident of the United States. This policy is not intended for residents of the United States.

Any person whose permanent full-time residence is in the United States is not eligible for this plan. A person who purchases the policy while living outside the country and moves back to the United States is eligible to apply for a 30-day extension. After 30 days, coverage will cease.

A resident of the United States is also defined as a person from another country who is in the United States for more than 90 days in any 12-month period. This applies to any days receiving medical care as well. After 90 days in the United States, consecutive or non-consecutive, there is no coverage.

The only exception to this rule is for full-time students under age 24 who are dependents on a policy where the primary insured lives outside of the United States. We must be notified of these students studying in US. There will be a surcharge on these U.S. residents.

I understand that I must notify Global Benefits Group immediately of any change in my and/or my dependents' residency. Failure to do so may result in the denial of claims as well as the recovery of any claims already paid. I also will complete a *Residence Verification Form* for my dependents if their residency is different than mine.

I will submit an address change directly to your main office located at:

26000 Towne Centre Drive Suite 100
Foothill Ranch, CA 92610 USA
Phone: (949) 470-2100 Fax: (949) 457-3116
E-mail: enroll@tiecare.com

My current information is as follows:

Street Address: ____________________

City, State: ____________________

Zip: ____________________

Country: ____________________

Phone Number: ____________________ Fax Number: ____________

E-mail Address: ____________________

____
Signature

____
Date