Application for Insurance – International Citizen Economy

Pacific Prime International

MULTINATIONAL UNDERWRITERS Lloyd's Coverholder

Part 1

Failure to provide complete information will delay processing.

	Deductibles	Dental Rider	Term Life
Economy	☐ $250 ☐ $1,000 ☐ $5,000 ☐ $500 ☐ $2,500	☐ Yes ☐ No	☐ Yes ☐ No
Requested Effective Date (must be within 30 days of signature)		Premium (from Part 5): $	

Note: Include only the family members applying for coverage. Attach additional sheets if necessary. Please print your name as you would like it to appear on your Identification Card.

Name (First name, middle initial, last name)		Date of Birth (mm/dd/yy)	Height	Weight	Citizenship	Optional Dental Rider
1. Applicant:	Male ☐ Female ☐	/ /				Yes ☐ No ☐
2. Spouse:	Male ☐ Female ☐	/ /				Yes ☐ No ☐
3. Name:	Male ☐ Female ☐	/ /				Yes ☐ No ☐
4. Name:	Male ☐ Female ☐	/ /				Yes ☐ No ☐
5. Name:	Male ☐ Female ☐	/ /				Yes ☐ No ☐

RESIDENT ADDRESS OUTSIDE THE UNITED STATES (required if US citizen)	MAIL FORWARDING ADDRESS FOR ALL WRITTEN CORRESPONDENCE (if different from Residence)
Must include Street Address, City, State, Country, and Postal Code:	Must include Street Address, City, State, Country, and Postal Code:

Your Occupation:	Employer Name:
Date Hired:	Prior Employment (if within 2 years):

Home Telephone Number:	Work Telephone Number:
Fax Number:	Email Address:

If you or any family member are a US citizen or if you are in the US now, the following information is required:	
Date of departure from US:	Length of Residence outside of US:

Part 2

Please answer all questions for all members of the family included in this Application.		
	Yes	**No**
1. Are you presently disabled, pregnant or unable to perform normal activities?		
2. Are you presently Hospitalized, or scheduled for or in need of Hospitalization or Surgery, or have you ever had, been recommended to have, or are you currently on a waiting list for any organ transplant?		
3. Have you ever had any indication, signs, symptoms, diagnosis, treatment, or tested positive for antibodies for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, or any other Immune System Disorder?		
4. Do you presently have or have you ever had Multiple Sclerosis, Parkinsons, Lou Gherigs disease (ALS), Down Syndrome or any form of mental retardation or chromosome disorder?		
5. Have you been diagnosed with or treated for any type of cancer or any form of diabetes during the last five (5) years?		
If any individual on the Application answers 'Yes' to any of the above questions, <u>they will not qualify for coverage under this plan.</u> Thank you for your interest.		
Questions 6-20 For any questions answered 'Yes' please identify the family member to whom the answer applies and provide details in Part 3.		
6. During the last 12 months, have you taken medication or received medical or mental health advice or treatment of any kind for any reason?		
7. Do you currently, or have you in the last 5 years, used tobacco in any form?		
Have you <u>ever</u> experienced symptoms of, manifestations of, suffered from, sought consultation, examination, testing or been treated for, or been prescribed medication, or have taken any type of over-the-counter medication, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from or relating to any of the following:		
8. Heart, cardiac, cardiovascular and/or circulatory systems (including but not limited to: angina, chest pain, elevated blood pressure, hypertension, heart attack, congestive heart failure, arteriosclerosis, atherosclerosis, rheumatic fever, heart murmur, mitral valve prolapse, tachycardia, atrial fibrillation, arrhythmia, swelling of feet/ankles, phlebitis, thrombosis, varicose veins)?		
9. Blood, blood vessels, veins, arteries or other blood anomalies (including but not limited to: hemophilia, leukemia, anemia, hepatitis, elevated cholesterol)?		
10. Cancer, tumor, cyst, polyp, lump, cell disorder, any condition or disease of the skin, or growth of any kind (including but not limited to: acne, any type of neoplasm, eczema, or psoriasis)?		
11. Eyes, ears, nose, mouth, gums, throat, tongue or jaw (including but not limited to: cataracts, glaucoma, hearing loss, sinusitis, deviated nasal septum, chronic sinus disorders, gum disease, dysphasia, TMJ)?		
12. Pancreas, gall bladder, liver, thyroid, obesity or any endocrine system (including but not limited to: pancreatitis, gall stones, hyper/hypo thyroidism, Cushing's syndrome, hepatitis)?		
13. Kidney, bladder, or urinary system (including but not limited to: kidney stones, renal failure, urinary incontinence, or chronic kidney, bladder or urinary tract infections)?		
14. Respiratory system (including but not limited to: asthma, allergies, allergic rhinitis, tuberculosis, lung disorder, emphysema, chronic cough, pneumonia)?		
15. Muscular or skeletal system (including but not limited to: scoliosis, disk disease, vertebrae or any back condition, rheumatism, fibromyalgia, any form of arthritis, gout, tendonitis, carpal tunnel syndrome, osteoporosis, any disorder of the tendons, cartilage, bone or joint)?		
16. Male or female reproductive system (including but not limited to: complicated pregnancy, menopause, ovarian cysts, uterine leiyoma, fibroids, breast cysts or nodules, infertility, prostatitis or elevated PSA level, testicular disorder, or any sexually transmitted disease)?		
17. Digestive or gastrointestinal system (including but not limited to: gastrointestinal or esophageal reflux, heartburn, gastritis, irritable bowl syndrome, ulcers, polyps, anal or rectal disorders)?		
18. Neurological system (including but not limited to: muscular dystrophy, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke or transient cerebral ischemic attacks)?		
19. Mental Health (including but not limited to: depression, psychosis, behavioral disorders, any form of Attention Deficit Disorder, chemical, alcohol or drug abuse or dependency, anxiety, chronic fatigue or any eating disorder)?		
20. Any other disease, medical problem, illness, injury, symptom, or condition of any kind?		

Part 3

For any question answered "Yes," please state the name of the family member (using the corresponding number from Part 1). Provide details of the condition including: treatment dates, name, address and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Attach additional pages if necessary. Additional information may be requested.

Individual's Name or Corresponding # from Part 1	Condition / Diagnosis	Dates of Treatment / Prognosis	Type(s) of Treatment and Present Course of Treatment	Physician and/or Facility Name, Address and Phone Number

Part 4

For each family member applying for Term Life Insurance, please complete the following (**Term Life is not available for those in the United States**):

	Basic Life	Supplemental Life
Applicant: Beneficiary:	☐ Yes ☐ No	☐ Yes ☐ No
Spouse: Beneficiary:	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Child: Beneficiary:	☐ Yes ☐ No	Not available

Provide full address for each Beneficiary listed above (attach additional sheets if necessary):

I understand Term Life Insurance will not become effective until the date of my departure from the US.

_____ (Applicant initial here) _____ (Spouse initial here) _____ (Initial here for Dependent Children)

Part 5

PREMIUM CALCULATION:

Applications without premium will not be processed. We will not accept checks or money orders for Monthly, Quarterly or Semi-Annual payment modes. For Monthly, Quarterly or Semi-Annual payment modes we will only accept a pre-authorized credit card. Either checks or credit cards may be used for Annual payment mode. Please make all checks payable to: MULTINATIONAL UNDERWRITERS, INC.

Medical: Enter the Annual Premium for each family member from the Rate Table for the plan and Deductible selected.

Applicant: $ _____
Spouse: $ _____
1st Child: $ _____
2nd Child: $ _____
3rd Child: $ _____
Subtotal A: $ _____

Optional Dental Rider: Enter the Annual Premium for each family member electing the Optional Dental Rider from the Optional Dental Rate Table.

Applicant: $ _____
Spouse: $ _____
1st Child: $ _____
2nd Child: $ _____
3rd Child: $ _____
Subtotal B: $ _____

Optional Term Life: Enter the Annual Premium for each family member from the Optional Term Life and AD&D Insurance Rate Table.

	Basic		Supplemental		Total
Applicant:	$ _____		$ _____		$ _____
Spouse:	$ _____		$ _____		$ _____
Child Life:	$ 85.00	X	_____ (# of children)	=	$ _____
			Subtotal C:		$ _____

Subtotal A:		$ _____
Subtotal B:	+	$ _____
Subtotal C:	+	$ _____
Total D (A+B+C)	=	$ _____

Total First Payment Due

$ _____ (Total D) X _____ *Modal Factor = $ _____

***Modal Factors:** **Annual 1.00** **Semi-Annual .55** **Quarterly .28** **Monthly .20**

Non-refundable Policy Fee $ 25.00

Optional Overnight mailing fee: ($20 in US, $30 outside the US) $ _____

Total First Payment Due: $ _____

Remaining Payments (For Semi-Annual, Quarterly, or Monthly Payment Methods Only)

$ _____ (Total D) X _____ *Modal Factor = $ _____

***Modal Factors:** **Semi-Annual .55** **Quarterly .28** **Monthly .10**

Premium Due For Each Additional Installment : $ _____

Monthly payments are available only if valid email address is provided:_____
All correspondence regarding monthly payments will be made via email to this address. For Monthly Payment method, there will be 10 additional monthly payments after initial payment.

Part 6

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to Members by Lloyd's. I have personally completed this Application. I represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I understand MultiNational Underwriters, Inc. relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meet the Underwriting and Eligibility requirements of the plan. I understand that any misrepresentation or omission contained herein will void my insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by MultiNational Underwriters, Inc. I understand that if this Application is not accepted, the sole obligation of MultiNational Underwriters, Inc. is to return any premium I have paid to me. I understand that this insurance contains a Pre-existing Condition Exclusion, a Pre-notification Penalty, and other restrictions, exclusions and limitations. I understand that I may obtain a copy of the Master Policy upon request to MultiNational Underwriters, Inc. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand that the insurance agent/broker, if any, assisting me with this Application, is a representative of the Applicant. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis or physical or mental condition of any family member listed on this Application to release said information to MultiNational Underwriters, Inc.

Signature of Applicant, Guardian or Power of Attorney	Signature of Spouse
Date of Signature	Date of Signature

Method of Payment

☐ Check or Money Order (Annual Payments only) ☐ American Express ☐ Discover ☐ MasterCard ☐ VISA

Check or Money Orders should be made payable, in US dollars, to MultiNational Underwriters, Inc. All payments must be made in US dollars. If paying by Credit Card, I authorize MultiNational Underwriters, Inc. to debit my VISA/Mastercard/American Express/Discover account for the total amount due. If I have selected Monthly, Quarterly, or Semi-Annual payment modes, I herby request and authorize MultiNational Underwriters, Inc. to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for up to 12 months or longer if the Certificate is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card company.

Credit Card Number:	Expiration Date (mm/yy):
Name as it appears on card:	Billing Address:
Daytime Phone Number:	Signature:

Part 7

Producer Number:	Producer Name: Pacific Prime International	
Company Name:	Street Address:	
City:	State:	Postal Code:
Country:	Telephone:	Fax:
E-Mail Address:	Signature:	

THIS MEDICAL, DENTAL AND LIFE INSURANCE IS UNDERWRITTEN BY CERTAIN UNDERWRITERS AT LLOYD'S, LONDON AND IS AVAILABLE TO MEMBERS OF THE ATLAS/INTERNATIONAL CITIZENS GROUP INSURANCE TRUST, HAMILTON, BERMUDA. LLOYD'S IS AN APPROVED NON-ADMITTED INSURER IN ALL STATES OF THE UNITED STATES, EXCEPT KENTUCKY AND ILLINOIS WHERE THEY ARE ADMITTED. CLAIMS UNDER THIS INSURANCE MAY NOT BE MADE AGAINST ANY STATE GUARANTY FUND.

Contact Information

In order to help us work with you more effectively we ask you to complete the following contact data sheet. By completing this fully then we will be able to ensure you get the best possible service even though you may change your employer, country or location.

Policyholder

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: ……..…… Family Name: ……..…..

Given Name: …… Middle Name(s): ……..……..

Home Address: ……..…

..... Country: ……..……

Contact info in the country you now live in

Mobile: …….. Home: …….. Work: ……..…….

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

Permanent contact information in your home country

Mobile: …….. Home: …….. Work: ……..….

Permanent Address: ……..……..……

..... Country: ……..……

Spouse

Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Other: …… Family Name: ……..…..

Given Name: …… Middle Name(s): ……..……..

Contact info in the country you now live in

Mobile: …….. Work: …….

Personal email (1): …….. Personal email (2): ……..

Work email: …….. Employer: ……..

Employers address: ……

..... Country: ……..……

Emergency Contact Person

In the event of an emergency whereby we are unable to contact you or your spouse or should you be incapacitated then please provide us with the permanent contact details of an immediate family member who we should contact in this situation.

Family Name: ……..…..... Given Name: …….

Mobile: …….. Home: …….. Work: ……..……

email: …….. Relationship to you: ……..

Home address: ……

..... Country: ……..……

Please help us by keeping us fully informed or all changes to your contact details as soon as possible. Please note all information given to us is only used to help us manage your insurance policy and is never used for any other purpose.