



For company use  
Policy number

# Individual Health Insurance Application

The Insurer retains the right to contact the applicant if any question is not explained in detail or if additional information is required.

New policy  Additional dependents  Change of plan

## 1 PERSONAL INFORMATION

Name of applicants (Policyholder/dependents)		Relationship to Policyholder	Marital status*	Date of birth Month/Day/Year	Sex	Weight	Height
First name: _____	M.I. _____	Policyholder		MM / DD / YYYY	M <input type="radio"/>	lbs kg	ft m
Last name: _____					F <input type="radio"/>		
First name: _____	M.I. _____			MM / DD / YYYY	M <input type="radio"/>	lbs kg	ft m
Last name: _____					F <input type="radio"/>		
First name: _____	M.I. _____			MM / DD / YYYY	M <input type="radio"/>	lbs kg	ft m
Last name: _____					F <input type="radio"/>		
First name: _____	M.I. _____			MM / DD / YYYY	M <input type="radio"/>	lbs kg	ft m
Last name: _____					F <input type="radio"/>		

If this Application includes children **19 years of age or older**, are any of them a full-time student in a college or university? ..... Yes  No

If "Yes," please indicate the name of the college or university: \_\_\_\_\_

If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm.

\*S—single M—married DP—domestic partner D—divorced W—widow **Note:** An Attending Physician Statement (APS) is required for any person **age 65 and older**.

## 2 PRODUCT, PLAN AND ADDITIONAL COVERAGE REQUESTED

Please select product: Bupa Complete Care: Worldwide  Latin America Only\*  Bupa Diamond Care: Worldwide  Latin America Only\*

Please select plan: 1  2  3  4  5  6  Other  \_\_\_\_\_

Premier 1 Renewals/Additions: Diamond  Gold  Gold LA  IHI Silver  Silver  Premier Care

Deductible value: \_\_\_\_\_

Requested Effective Date of Coverage: MM / DD / YYYY Additional coverage: Maternity complications

Other  \_\_\_\_\_

\*Excludes Mexico

## 3 PREVIOUS INSURANCE INFORMATION

(3.1) Will the requested coverage replace any existing insurance? ..... Yes  No

If "Yes," please attach copy of certificate of coverage, and receipt of last payment.

Company Name: \_\_\_\_\_

Product Name: \_\_\_\_\_

Deductible Value: \_\_\_\_\_ Policy No.: \_\_\_\_\_

### 3 PREVIOUS INSURANCE INFORMATION (continued)

(3.2) Has any previous application for health or life insurance been declined, accepted subject to restrictions, or at a premium higher than the standard rates of the insurer for any of the applicants? .....Yes  No

If "Yes," please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 4 GENERAL INFORMATION

#### (4.1) Address

Home	_____		
Zip code:	_____	City/State:	_____
		Country of residence:	_____
Mailing (if different from above)	_____		
Zip code:	_____	City/State:	_____
		Country:	_____

#### (4.2) Residence/Citizenship Status

Are you a U.S. Citizen or permanent resident of the United States of America? Yes  No

If the answer is "Yes," have you legally resided in the United States of America for more than 6 months in any one year period? Yes  No

#### (4.3) Telephones, fax and e-mail

Home	Country code	Area code	Number	Work	Country code	Area code	Number
	_____	_____	_____		_____	_____	_____
Fax	Country code	Area code	Number	E-mail	_____		
	_____	_____	_____		_____		

### 5 BENEFICIARY INFORMATION

Names of beneficiaries				Relationship to Policyholder	
First name:	_____	M.I.	_____		
Last name:	_____				
First name:	_____	M.I.	_____		
Last name:	_____				

### 6 MEDICAL INFORMATION

#### (6.1) Family doctor(s)

Applicant	Doctor's name	Specialty	Telephone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



## 6 MEDICAL INFORMATION (continued)

### (6.4) Medical condition(s) / Explanation(s) (continued)

Question □	Applicant: □□□□□□□□□□□□□□□□	Condition: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY
Treatment and results: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□		Current state of health: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□	Doctor's information: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□	

  

Question □	Applicant: □□□□□□□□□□□□□□□□	Condition: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY
Treatment and results: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□		Current state of health: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□	Doctor's information: □□□□□□□□□□□□□□□□ □□□□□□□□□□□□□□□□	

If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm.

### (6.5) Medication(s)

Is any applicant currently taking medication, or been advised at any time to take any medication? ..... Yes  No  If "Yes," please explain below.

Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY
Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY
Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY
Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: MM/DD/YYYY	To: MM/DD/YYYY

If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm.

### (6.6) Habit(s)

Has any applicant ever smoked cigarettes, consumed nicotine products, alcohol or illegal drugs? ..... Yes  No   
If "Yes," please explain below.

Applicant: □□□□□□□□□□□□□□□□	Type: □□□□□□□□□□□□□□□□	Amount per day: □□□□□□□□□□□□□□□□
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### (6.7) Family history

Does any applicant have a family history of diabetes, hypertension, cancer, or a congenital or hereditary cardiovascular disorder? ..... Yes  No  If "Yes," please explain below.

Applicant	Relative with the disorder (please check)				Disorder
	Father	Mother	Sibling	Child	
□□□□□□□□□□□□□□□□	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	□□□□□□□□□□□□□□□□
□□□□□□□□□□□□□□□□	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	□□□□□□□□□□□□□□□□

## 7 ACKNOWLEDGEMENT AND AUTHORIZATION

I hereby accept that International Health Insurance danmark a/s, IHI (the Insurer), will record the information given for the purpose of processing data in connection with premium collection, processing of claims, reimbursements, etc. In case of non acceptance of the Application, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. I also accept that all correspondence concerning the insurance will be sent to the person registered as the Policyholder. The Insurer may choose to have data processed in or outside the European Union.

I, the undersigned, solemnly declare that I am in excellent health and do not suffer from any recurring illness or physical debility, except as disclosed on this Application. If any person requires medical care or treatment after the Application for insurance is signed, but before the effective date of this Policy, I will then provide full details to the Insurer for final approval before coverage is effective. I further declare that, to the best of my knowledge and belief, all information on the Application is true. I acknowledge that any misrepresentation or nondisclosure of information requested may result in no coverage or modification of coverage under the Policy. I acknowledge and understand that acceptance of this Application by the Insurer will be made in reliance on the accuracy of the information presented in the application.

I declare that I have received and read the Policy Conditions and accept that the Policy Conditions together with the Certificate of Coverage and the Application will represent the insurance contract with the Insurer, if the Application is accepted. If I do not accept, I will notify my disagreement to the Insurer in writing, within the first ten (10) days of receipt of the insurance policy. I also declare that I am not a resident of the United States of America.

In the event that I am represented by a Producer, I hereby authorize that person to receive my Policy Conditions, Certificate of Coverage, and all documents related to my coverage.

## 8 AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person having any records or knowledge of myself or my health, including any member of my family, to give any such information to International Health Insurance danmark a/s, Bupa, USA Medical Services, and their affiliates. A copy of this authorization shall be as valid as the original. This authorization shall remain valid as long as any insurance is in effect.

## 9 SIGNATURE: My signature below constitutes acceptance of all items listed above (all dependents after 18 years of age must sign). A parent or person with legal custody of the child must sign of behalf of any applicant under 18 years of age.

Applicant's Signature:  X	Applicant's printed name:  _____	Date:  ____/____/____ MM DD YYY
Spouse's Signature:  X	Spouse's printed name:  _____	Date:  ____/____/____ MM DD YYY
Dependent's Signature:  X	Dependent's printed name:  _____	Date:  ____/____/____ MM DD YYY
Dependent's Signature:  X	Dependent's printed name:  _____	Date:  ____/____/____ MM DD YYY

As Producer, I accept full responsibility for the submission of this Application, sending all the collected premiums, and for the delivery of the Policy when issued.

**I do not know of any condition that has not been disclosed in this Application which will affect the insurability of the proposed insureds.**

Producer's Signature (witness):  X	Producer's printed name: <b>Good Neighbor Insurance, Inc</b> Email: info@gninsurance.com Phone: 480.633.9500 (Toll free: 866.636.9100) Fax: 480.813.9930 Address: 690 E. Warner Rd., Ste. 117 Gilbert, AZ 85296 USA	Producer's Code: <b>8622</b>
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**10 PAYMENT INFORMATION (payment must be submitted with the Application)**

Policy type:  Annual  
 Semi-Annual  
 Quarterly

Premium: US \$ \_\_\_\_\_  
Optional health rider(s): US \$ \_\_\_\_\_  
Annual administrative fee: US \$ 75.00  
Total amount: US \$ \_\_\_\_\_

**Payment Method: Option 1**

Cashier's check  Check  Money order  Traveler's check

Note: **DO NOT SEND CASH.** Payment must be made to: Bupa Worldwide Corporation

**Payment Method: Option 2**

Wire transfer Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 063000021, Swift Number: PNBPU33

**Payment Method: Option 3**

ACH Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 067006432

**Payment Method: Option 4**

Credit card Please provide the following information:

I, \_\_\_\_\_, authorize Bupa Worldwide Corporation

to charge my credit card:        

Credit card number \_\_\_\_\_ Expiration date \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ CVC \_\_\_\_\_

Amount to charge US \$ \_\_\_\_\_

Identity Card number \_\_\_\_\_ (For Venezuelan residents only)

Cardholder's billing address (where the credit card statement is received)

\_\_\_\_\_

Cardholder's phone number \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

**AUTOMATIC DEBIT FOR FUTURE RENEWALS** ..... Yes  No

My signature on this document hereby authorizes Bupa Worldwide Corporation to debit the credit card and/or bank account directly, as indicated above, and pay the insurance premiums of my IHI health insurance Policy.

I understand that if there are any changes to my IHI insurance Policy, the amount of the approved premium may also change. I further understand that a true and correct copy of this document will be forwarded to my credit card and/or banking institution. In signing this document, I request and instruct the institution to allow Bupa Worldwide Corporation to directly debit my account and pay the health insurance premium, unless I instruct otherwise in writing.

In the event that a direct debit to pay my IHI health insurance Policy is, for any reason, rejected or declined, I acknowledge that it will be my personal responsibility to immediately pay the premiums of my health insurance Policy, or that my policy may lapse, be cancelled and/or terminated.

By signing, I authorize automatic deductions for future renewals.

\_\_\_\_\_  
Policyholder's Signature

\_\_\_\_\_  
Cardholder's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY  
Date

## TEMPORARY EMERGENCY COVERAGE

This Temporary Emergency Coverage does not provide any coverage except as specified below and is subject to the fulfillment of all the terms and conditions. It is only valid when the full modal premium selected is included with the Application.

### AMOUNT OF TEMPORARY EMERGENCY COVERAGE

From the time the Application and total premium for this Policy are received by the Insurer, International Health Insurance danmark a/s, hereinafter known as IHI, through the effective date of the Policy, or thirty (30) days from the date said Application is received by the Insurer, whichever date comes first, the Insurer agrees to insure all the proposed Insureds (including spouse and children) for covered medical expenses resulting from accidental bodily injury incurred while this Temporary Emergency Coverage is in effect, up to a maximum benefit of twenty-five thousand dollars (\$25,000) per Policy. This temporary accident coverage is subject to and governed by the respective Policy terms, provisions, and exclusions which would have been applicable, had the Policy been in effect on the date of the accident of the proposed Insured.

This benefit is subject to the deductible for the plan chosen by the proposed Insured and does not apply if the Application is declined for any reason or the Policy is rejected by the Insured after it has been issued. The injuries sustained in an accident while the Application is being evaluated cannot be a reason to decline an Application.

### CONDITIONS THAT MUST BE MET FOR THE TEMPORARY EMERGENCY COVERAGE TO BE EFFECTIVE

1. Application duly completed.
2. All medical and non-medical requirements and any other information requested by IHI are received in our offices.
3. The proposed Insured must be insurable according to the Insurer's underwriting guidelines.
4. The premium sent with the Application must equal or exceed the first modal minimum premium and must be in US currency payable to Bupa Worldwide Corporation.
5. Said premium must be good and collectible if paid by check, draft, credit card or money order before the coverage goes into effect.
6. The Policy is not declined by the Insured after it has been issued.

All the statements and answers included in this Application are true, complete and correctly stated to the best of my knowledge and shall be the basis for any policy issued on this Application. Any omissions or incorrect or incomplete statements may result in the denial of a claim, the modification of the contract, or the rescission of the insurance Policy, pursuant to the terms and conditions of the Policy.

All the above conditions must be met in order for the temporary coverage to be in effect. The temporary coverage will terminate when the coverage applied for is effective, denied, or when coverage other than applied for is offered. The temporary coverage is valid for 30 days from the date of receipt of the Application, and premium, and will terminate thereafter.

The Producer, representative, or agent does not have authority to waive or alter any of the conditions, cannot bind IHI to accept the risk, and cannot change any of the terms of this document.

This coverage is not valid until payment made to Bupa Worldwide Corporation is rendered and the funds are deposited. I, therefore, authorize Bupa Worldwide Corporation to charge or deposit my premium payment in order to receive this coverage.

I have read and understood all the conditions contained in this document.

-----  
Signature of Applicant

-----  
Date (MM/DD/YYYY)

I hereby certify that I received the sum of US\$ \_\_\_\_\_ as payment for the health insurance of

-----  
Applicant's Name

requested on this date.

-----  
Producer's Name

-----  
Producer's Signature

-----  
Date (MM/DD/YYYY)



Please cut along the dotted line

## Copy for the Policyholder

### AMOUNT OF TEMPORARY EMERGENCY COVERAGE

From the time the Application and total premium for this Policy is received by the Insurer, IHI, through the effective date of the Policy, or thirty (30) days from the date said Application is received by the Insurer, whichever date comes first, the Insurer agrees to insure all the proposed Insureds (including spouse and children) for covered medical expenses resulting from accidental bodily injury incurred while this Temporary Emergency Coverage is in effect, up to a maximum benefit of twenty-five thousand dollars (\$25,000) per Policy. This temporary accident coverage is subject to and governed by the respective policy terms, provisions, and exclusions which would have been applicable, had the Policy been in effect on the date of the accident of the proposed Insured.

This benefit is subject to the deductible for the plan chosen by the proposed Insured and does not apply if the Application is declined for any reason or the Policy is rejected by the Insured after it has been issued. The injuries sustained in an accident while the Application is being evaluated cannot be a reason to decline an Application.