

APPLICATION FORM



☐ BEST DOCTORS INSURANCE LIMITED

Important: Please make sure all the information required on this application has been provided. Best Doctors Insurance Limited reserves the right to contact the applicant if a question hasn't been answered in detail or if additional information is needed. Any incomplete applications will be returned to the applicant for more information, delaying the processing of your application.

- New application**
- Change my current plan/option
- Add spouse/partner/dependents

☐ APPLICANT INFORMATION

LAST NAME(S)

FIRST NAME(S)

STREET ADDRESS

CITY

COUNTRY

EMAIL ADDRESS

TELEPHONE (OFFICE OR MOBILE NUMBER)

FAX

DATE OF BIRTH (MM/DD/YY)

HEIGHT

M FT

WEIGHT

KG LB

OCCUPATION

GENDER

- Male
- Female

STATUS

- Single
- Married
- Widowed
- Divorced

ASA, Inc.
International Insurance Consultants
1300 N. McClintock Dr. Ste A
Chandler, AZ 85226-7240

Phone: 480-753-1333
Toll Free: 888-ASA-8288 (within U.S. only)
Fax: 480-753-1330
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Internet: www.asaincor.com

Continued over

SELECT PLAN

Premier Plus

Global Care

Ultimate Care

Advanced Care

Other _____

SELECT OPTION

I V

II VI

III

IV

ADDITIONAL COVER (RIDER)

Maternity Complications

Organ Transplant

Critical Select

Other _____

*Option VI Only for Ultimate Care

DEPENDENT'S INFORMATION

1. FIRST AND LAST NAME(S)

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YY) _____ HEIGHT _____ M FT _____ KG LB _____ PREMIUM (USD) _____

2. FIRST AND LAST NAME(S)

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YY) _____ HEIGHT _____ M FT _____ KG LB _____ PREMIUM (USD) _____

3. FIRST AND LAST NAME(S)

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YY) _____ HEIGHT _____ M FT _____ KG LB _____ PREMIUM (USD) _____

4. FIRST AND LAST NAME(S)

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YY) _____ HEIGHT _____ M FT _____ KG LB _____ PREMIUM (USD) _____

5. FIRST AND LAST NAME(S)

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YY) _____ HEIGHT _____ M FT _____ KG LB _____ PREMIUM (USD) _____

APPLICANT (SELF) PREMIUM (USD)

RIDER (USD)

75

ANNUAL ADMINISTRATION FEE (USD)

TOTAL (USD)

INFORMATION REGARDING ANY OTHER MEDICAL COVERAGE

Y N Indicate if you or any of your dependents have any other type of international health insurance.

If YES, please attach a copy of the plan's certificate of coverage and last payment receipt.

Y N Do you intend to continue being insured with the other company?

Y N Have you ever had an application for health insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? **If YES,** please enclose complete information.

Y N Have you ever been insured by Best Doctors Insurance Limited or any one of its affiliates?

If YES, indicate date (MM/DD/YY) _____

If this is a change of plan/option, please indicate previous policy number _____

☐☐☐ MEDICAL QUESTIONNAIRE ANSWER **Y** **YES** OR **N** **NO** TO ALL QUESTIONS BELOW

SECTION A: To the best of your knowledge, have any of the persons listed on this application had any of the following conditions during the last ten (10) years?

- Y N a) Cancer, malignant tumors or benign tumors. **If YES**, indicate type _____
- Y N b) Kidney stones, kidney or bladder problems, urinary frequency or burning
- Y N c) Goiter, thyroid problems or diabetes
- Y N d) Epilepsy, paralysis, mental or nervous diseases, liver problems, alcoholism
- Y N e) Drug addiction for which the individual has been treated or hospitalized
- Y N f) Gall bladder problems, hernia, stomach or intestinal problems, ulcers, hemorrhoids
- Y N g) Cataracts or other eye problems, ear problems
- Y N h) Tuberculosis, pulmonary diseases, asthma or bronchitis, sinusitis, chronic cough and throat problems
- Y N i) Arthritis, rheumatism, joint deformation due to arthritis, spine problems, gout
- Y N j) Heart disease, blood pressure problems, anemia, and rheumatic fever
- Y N k) Female: Menstrual alterations or menstrual hemorrhage, disorders of the reproductive organ, sexually transmitted diseases, breast disorders
- Y N l) Female: Presently pregnant. **If YES**, indicate date of delivery (MM/DD/YY) _____
- Y N m) Female: Indicate number of: Pregnancies _____ Childbirths _____ Abortions _____
- Y N n) Female: Complications of pregnancy or childbirth, twin pregnancy or a child with any birth defect, congenital disease or hereditary condition
- Y N o) Male: Prostate problems, sexually transmitted diseases
- Y N p) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)
- Y N q) Dermatitis or skin diseases, skin cancer, or any other skin problem

SECTION B: Besides the health problems mentioned in Section A, to the best of your knowledge and understanding is there any person listed on this application who during the last five (5) years:

- Y N a) Has consulted a doctor or other provider for surgical or medical treatment or for advice regarding another illness not mentioned in Section A?
- Y N b) Had any health problem or symptom not mentioned in Section A or on Question (a) of this section, for which he/she has or has not consulted doctors?
- Y N c) Have taken or takes any kind of medicine on a regular basis? **If YES**, please state:

NAME OF PATIENT

DIAGNOSIS

TYPE OF MEDICINE AND DAILY DOSAGE

EXPENSE PER MONTH

LAST MEDICAL CHECK UP (MM/DD/YY)

NAME OF YOUR PRIMARY DOCTOR

TELEPHONE OF PRIMARY DOCTOR

ADDRESS OF PRIMARY DOCTOR

SECTION C: If you have answered **YES** on any part of Sections A or B please provide complete information in this section and attach the medical report (you may use an additional page if you need more space).

1. NAME OF PATIENT _____ DIAGNOSIS AND TREATMENT _____

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL _____ DATE (TO/FROM) _____

2. NAME OF PATIENT _____ DIAGNOSIS AND TREATMENT _____

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL _____ DATE (TO/FROM) _____

3. NAME OF PATIENT _____ DIAGNOSIS AND TREATMENT _____

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL _____ DATE (TO/FROM) _____

ACKNOWLEDGEMENT AND AUTHORIZATION

IT IS UNDERSTOOD AND AGREED THAT:

- a) Best Doctors Insurance Limited (the Insurance Company) reserves the right to accept or reject any Enrollment Application. The coverage provided will not become effective until the Insurance Company has received premium payment and approved the Application. The coverage will become effective on the first day of the month following the date on which the Insurance Company approves the Application.
- b) The statements and answers provided are complete and true according to my best knowledge and understanding. If there is any false statement on this Application (if such statements or material for the acceptance of this Application are fraudulent), then the contract can be annulled by the Insurance Company, and its obligation should consist only of the reimbursement of any application expense paid, minus the amount of any benefit paid under this contract.
- c) The Applicant should reimburse the Insurance Company the amount of any payment resulting from a claim made by error to the Applicant in favour of the Applicant or any member of the family covered under the contract.
- d) Upon presentation of a photocopy or original of this signed Application, I authorise any physician, professional, hospital, clinic, or other medical provider, government agency or other person or company to provide the Insurance Company information including copies of records concerning counsel, care or treatment provided to me and/or my dependent(s), without limitation to information concerning mental illness or use of drugs or alcohol.
- e) The Insured and covered dependents specifically understand and agree that they have elected to allow the agent of record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates of subcontractors.

SIGNATURE OF APPLICANT _____ SIGNATURE OF AGENT _____

DATE (MM/DD/YY) _____ AGENT NAME _____

BDUSASA000
AGENT CODE

PAYMENT INFORMATION

PAYMENT FREQUENCY	PAYMENT METHOD	PAYMENT SUMMARY
<input type="checkbox"/> Annual	<input type="checkbox"/> Credit card	_____ PREMIUM (USD)
<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Cheque: Make payable to Best Doctors Insurance Limited.	_____ RIDER (USD)
	<input type="checkbox"/> Wire transfer	75
		ANNUAL ADMINISTRATION FEE (USD)
		TOTAL (USD)