Application for **Individual Health Insurance**

New policy ◯ | Policy reinstatement ◯ | Dependent addition ◯ | Change of plan/option ◯

Section I. Applicant **Information**

1. Last name(s): | 2. First name: | 3. Middle initial:

4. Address:

5. City: | 6. State: | 7. Zip code: | 8. Country:

9. Phone number (office or cell): + - - | 10. Fax: + - - | 11. Email address:

12. Occupation: | 13. Marital status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

14. Date of birth: M M / D D / Y Y Y Y | 15. Gender: ◯ Male ◯ Female | 16. Height: ◯ Meters ◯ Feet | 17. Weight: ◯ Kilos ◯ Pounds

18. If this application includes dependents between the ages of 19 and 24 years old:

Is any of them a full-time university student? ◯ Yes ◯ No

18a. If you answered **"Yes"** please provide the name of the school and a copy of the university's certificate or affidavit as evidence that they are full-time students:

Section II. Choose your **Coverage**

1. Effective date requested: M M / D D / Y Y Y Y

2. Plan:
- ◯ Absolute VIP
- ◯ Universal VIP
- ◯ Special VIP
- ◯ Optimum VIP
- ◯ Senior VIP

3. Option: ◯ I ◯ II ◯ III ◯ IV ◯ V ◯ VI

4. Additional coverage:
- ◯ Maternity and newborn complications
- ◯ Organ transplant
- ◯ Life term insurance
  Name of the beneficiary and relationship to the applicant: ◯ Applicant ◯ Spouse / Domestic Partner
  Option: ◯ US$50,000 ◯ US$100,000

Section III. Dependent **Information**

DEPENDENT 1

1. Last name(s): | 2. First name: | 3. Middle initial: | 4. Relationship to the applicant:

5. Date of birth: M M / D D / Y Y Y Y | 6. Gender: ◯ Male ◯ Female | 7. Height: ◯ Meters ◯ Feet | 8. Weight: ◯ Kilos ◯ Pounds

9. Marital status: ◯ Single ◯ Other

DEPENDENT 2

1. Last name(s): | 2. First name: | 3. Middle initial: | 4. Relationship to the applicant:

5. Date of birth: M M / D D / Y Y Y Y | 6. Gender: ◯ Male ◯ Female | 7. Height: ◯ Meters ◯ Feet | 8. Weight: ◯ Kilos ◯ Pounds

9. Marital status: ◯ Single ◯ Other

Section IV. Other Insurance **Information**

1. Do you have health insurance with another company? ◯ Yes ◯ No

1a. Name of the company:

1b. Phone number: + - -

1c. Plan:

1d. Deductible amount:

1e. Policy number:

1f. Do you plan to keep the health insurance with the other company? ◯ Yes ◯ No

If you wish the waiting period to be eliminated, please include a copy of the certificate of coverage and the payment receipt of the last 12 months of the prior coverage.

2. Has any health or life insurance application been rejected or accepted subject to restrictions, or to a higher premium than the standard rates of the company for any of the applicants? ◯ Yes ◯ No

2a. If you answered **"Yes"** please explain:

Section V. Medical **Information**

Part A: Medical Exams

Has any of the applicants had a pediatric, gynecological or routine examination within the last five (5) years? ◯ Yes ◯ No

If yes, please explain:

MEDICAL EXAM 1

1. Applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result: ◯ Normal ◯ Abnormal

5. If abnormal, please explain:

MEDICAL EXAM 2

1. Applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result: ◯ Normal ◯ Abnormal

5. If abnormal, please explain:

MEDICAL EXAM 3

1. Applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result: ◯ Normal ◯ Abnormal

5. If abnormal, please explain:

Part B: Medical Conditions

To the best of your knowledge and understanding, has any of the listed applicants suffered or currently suffer from any of the following diseases?

1. Nasal, vision, ear or throat disorders ◯ Yes ◯ No
2. Seizures, migraines, paralysis or other neurological disorders ◯ Yes ◯ No
3. Heart disorders, circulatory disorders, hypertension, high cholesterol or triglycerides ◯ Yes ◯ No
4. Allergies, asthma, bronchitis, pneumonia, lung disorder or other disorders of the respiratory system ◯ Yes ◯ No
5. Diseases of the esophagus, stomach, intestines, pancreas, gall bladder, hepatitis or other liver diseases as well as other disorders of the digestive system ◯ Yes ◯ No

Section V. Medical **Information** (continued)

6	Kidney or urinary tract diseases	◯ Yes ◯ No
7	Spinal disorders or injuries, rheumatism, arthritis, gout or other muscular, joints or bone disorders	◯ Yes ◯ No
8	Cancer or benign tumors	◯ Yes ◯ No
9	Anemia, leukemia, lymphoma, coagulation disorders or other blood disorders	◯ Yes ◯ No
10	Diabetes, thyroid disorder or other endocrine/hormonal disorder	◯ Yes ◯ No
11	Skin disorders	◯ Yes ◯ No
12	Congenital or hereditary disorders	◯ Yes ◯ No
13	Sexually transmitted diseases or sexual organs or reproductive system disorders	◯ Yes ◯ No
14	Male: prostate disorders	◯ Yes ◯ No
15	Female: breast, ovaries, uterus or other gynecological disorders	◯ Yes ◯ No
16	Female: currently pregnant? (if affirmative please provide the expected due date): M M / D D / Y Y Y Y 16a. Number of pregnancies: ..... 16b. Deliveries: ..... 16c. C-sections: ..... 16d. Abortions:	◯ Yes ◯ No
17	Female: pregnancy or delivery complications, multiple pregnancy, or a child with a birth defect	◯ Yes ◯ No
18	Any other disease, disorder, injury, accident, surgery, medical consultation, sudden weight loss, or hospitalization not mentioned above	◯ Yes ◯ No

Part C: Explanation of Medical Conditions

MEDICAL CONDITION 1

1. Number: 2. Applicant: 3. Illness or injury:

4. From M M / D D / Y Y Y Y 6. Physician's name: 8. Treatment, results and current condition:

5. To: M M / D D / Y Y Y Y 7. Physician's phone number: + - -

MEDICAL CONDITION 2

1. Number: 2. Applicant: 3. Illness or injury:

4. From M M / D D / Y Y Y Y 6. Physician's name: 8. Treatment, results and current condition:

5. To: M M / D D / Y Y Y Y 7. Physician's phone number: + - -

MEDICAL CONDITION 3

1. Number: 2. Applicant: 3. Illness or injury:

4. From M M / D D / Y Y Y Y 6. Physician's name: 8. Treatment, results and current condition:

5. To: M M / D D / Y Y Y Y 7. Physician's phone number: + - -

Section V. Medical **Information** (continued)

Part D: Medication

Has any of the applicants been prescribed or is currently under treatment with any medication? ◯ Yes ◯ No

If yes, please explain:

MEDICAL TREATMENT 1

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 2

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 3

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

Part E: Habits

Do any of the applicants use or has used nicotine products, alcoholic beverages or illegal drugs? ◯ Yes ◯ No

If yes, please explain:

TYPE OF HABIT 1

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Product and amount consumed per day:

TYPE OF HABIT 2

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Product and amount consumed per day:

TYPE OF HABIT 3

1. Applicant: | 2. From: M M / D D / Y Y Y Y | 3. To: M M / D D / Y Y Y Y

4. Product and amount consumed per day:

Section VI. Family **History**

Do any of the applicants has a family history of diabetes, hypertension, heart disorders, cancer or congenital or hereditary diseases? ◯ Yes ◯ No

If yes, please explain:

FAMILY HISTORY 1

1. Applicant:

2. Relationship to the applicant:

3. Disease:

FAMILY HISTORY 2

1. Applicant:

2. Relationship to the applicant:

3. Disease:

FAMILY HISTORY 3

1. Applicant:

2. Relationship to the applicant:

3. Disease:

Section VII. Acknowledgement and **Authorizations**

I certify that I have read and reviewed all answers and statements in this application, and that to the best of my knowledge the information is complete and correct. I understand that any omissions, incomplete statements, or incorrect answers may cause claims not to be approved and may also cause the policy to be modified, rescinded or cancelled. If any of the insureds require care or medical treatment after the insurance application has been signed, but before the effective date of the policy, you must provide full details to the Company for final approval before coverage becomes effective. I agree to accept the policy under the terms and conditions issued. Otherwise, I will notify my disagreement in writing to the Company within fifteen (15) days of receipt of the insurance policy.

Authorization to collect and disclose information about my health

I hereby authorize VUMI or VIP Universal Medical Group, Limited, its subsidiaries and affiliates to request my medical records and/or those of my dependents, as well as any prescription drug history and any other medical or pharmaceutical information to be considered in the risk assessment process regarding the request for coverage for myself and my dependents. I authorize any physician, hospital, laboratory, pharmacy or other medical provider, health plan, the Medical Information Bureau (MIB), or any other organization or person, including any family member who has medical records or knowledge of me or my health to disclose such information to VUMI or VIP Universal Medical Insurance Group, Limited or its designated representatives. Likewise, I hereby authorize VUMI or VIP Universal Medical Insurance Group, Limited and its subsidiaries and affiliates to disclose to my agent/insurance agency, affiliates, successors and the Medical Information Bureau (MIB) the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage and claims payments. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

The existence of any information and documentation described above shall be disclosed with this application. I understand that VUMI will use this information to:

1) Assess the risk of application for coverage and make decisions about eligibility, risk rating, policy issuance and registration of all applicants.
2) Administer claims and determine or fulfill liability coverage and providing benefits.
3) Administer coverage.
4) Conduct other insurance operations according to applicable law.

I understand that the ability of VUMI to assess coverage is based on receiving all necessary health information.

MIB Pre-Notice

Information regarding your insurability will be treated as confidential. VUMI or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

At your request, MIB will arrange disclosure of any information it may have in your file, please contact MIB at +1-866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. VUMI, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

I authorize VUMI, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

I have reviewed and understand the contents and purpose of this acknowledgement and authorization. By responding and signing this, I am confirming my desire to request this coverage. My signature below constitutes my agreement to all statements listed above. This application is valid for 90 days from the date on which it was signed. I understand that I can revoke this authorization at any time by giving written notice to VIP Universal Medical Insurance Group, Limited at the address shown below. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

1. Applicant's name:

2. Applicant's signature:

3. Date: M M / D D / Y Y Y Y

4. Spouse's name:

5. Spouse's signature:

6. Date: M M / D D / Y Y Y Y

As Agent, I accept full responsibility for submitting this application, all premiums collected and the delivery of the policy when issued. I do not know the existence of any condition that has not been disclosed in this application that could affect the insurability of the proposed insured.

7. Agent's name:

126120

8. Agent's signature:

9. Date: M M / D D / Y Y Y Y

Section VIII. Payment **Information**

(payment must be submitted with the application)

1. Applicant's name:

2. Policy number:

3. Payment frequency:

- ◯ Annual
- ◯ Semi-annual
- ◯ Quarterly

Premium	US$	
Optional coverage	US$	
Annual administrative fee	US$	
Total amount	US$	

Payment method OPTION 1:

◯ Check ◯ Personal check ◯ Bank transfer ◯ Traveler's check ◯ Other

DO NOT SEND CASH. Payment must be issued to VIP Universal Medical Insurance Group.

Payment method OPTION 2:

◯ Credit card

Please provide the following information:

I, _____ authorize VIP Universal Medical Insurance Group to charge my credit card

◯ MasterCard ◯ VISA ◯ AMERICAN EXPRESS ◯ DISCOVER

1. Credit card's number: ____ - ____ - ____ - ____

2. Expiration date: M M / Y Y Y Y

3. CVC:

4. Amount to charge: US$

5. Cardholder's phone number: + ___ - ___ - _____

6. Cardholder's cell phone number: + ___ - ___ - _____

7. Cardholder's address (where statement is received):

8. Cardholder's signature:

Automatic debit for future renewals: ◯ Yes ◯ No

By signing this document, I authorize VIP Universal Medical Insurance Group to automatically debit the above credit card and/or bank account to pay for the premiums of my VUMI health insurance policy.

I understand that if there are any changes to my VUMI health insurance policy, the approved amount of the premium may change. I also understand that a true and correct copy of this document will be sent to my bank or credit card company. By signing this document, I request and instruct the relevant institution to allow VIP Universal Medical Insurance Group to directly debit my account and pay for the health insurance premium, unless I state otherwise in writing.

In the event that a direct debit is, for any reason, rejected or denied, I agree that I have a personal responsibility to immediately pay the premiums of my health insurance policy or the policy may be rescinded, suspended or canceled.

By signing, I authorize automatic deductions for future renewals.

Cardholder's signature:

Cardholder's phone number: + ___ - ___ - _____

VIP Universal Medical Insurance Group, LTD
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