GLOBAL BENEFITS GROUP
Insurance Without Borders

Application for Individual Coverage

Instructions:

1. **You are responsible for completing this application and are solely responsible for its accuracy and completeness.**
2. **All questions must be answered in full; all signatures and dates must be included where noted; otherwise the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.**
3. **Type or print clearly using blue or black ink.**

Applicant's Name:	

Section 1: Insurance Policy Selection: Please complete this section to tell us what insurance you are interested / applying for.

Enrollment Type: ☐ New Enrollment ☐ Add Spouse, Date of Marriage: _____ ☐ Add Child ☐ Other_____

Currency of Benefits: ☐ **U.S. Dollar ($)** ☐ **Euro (€)** ☐ **British Pound (£)** ☐ **Canadian Dollar (C$)** ☐ **CNY (¥)**

Medical Insurance Coverage

Choose One:	☐ Worldwide (No Area Exclusions) ☐ International (No Coverage in U.S. or Canada) ☐ International Plus (Emergency Coverage in U.S. or Canada)
Annual Deductible:	☐ $100 ☐ $250 ☐ $500 ☐ $1,000 ☐ Other _____
Co-payment:	☐ 0% ☐ 10% ☐ 20% ☐ 30%

Other Insurance Coverage

☐ **Life Insurance**	Sum Assured: _____
☐ **Long Term Disability Insurance**	• Benefit (% Salary): ☐ 60% ☐ 66 $^{2}/_{3}$% ☐ 70% • Deferred Period (weeks): ☐ 13 ☐ 26 ☐ 52
☐ **Short Term Disability Insurance**	• Benefit (% Salary): ☐ 60% ☐ 66 $^{2}/_{3}$% ☐ 70% ☐ 80% per month • Policy Period (weeks): ☐ 13 ☐ 26 ☐ 52 • Deferred Period (days): ☐ 14 ☐ Other _____
☐ **Accidental Death & Dismemberment Insurance**	Sum Assured: _____

Method of Payment:	☐ Annual ☐ Semi-Annual **(add 5% surcharge)** ☐ Quarterly **(add 5% surcharge)** ☐ Monthly **(add 5% surcharge)** **If premium is <u>under</u> $5,000: Annual Payment only**

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Please complete sections 2 through 5 to provide additional information about yourself and your dependents (if applicable).

Section 2-A: Applicant Details

Last Name:	First Name:	Gender: Male ◯ Female ◯	Height / Weight: m / feet: lbs / kgs:	Marital Status: Single / Married / Domestic Partner / Divorced / Widowed
Date of Birth (mm/dd/yy):	Citizenship:	Nationality:	Country of Residence:	

Address:	City:	State:	Postal Code:	Country:
Email Address:	Phone Number:	Have you ever been covered by Global Benefits Group Before? ☐ Yes ☐ No		

Employer Name:	Employer Address:	
Annual Salary (Specify Currency):	Occupation and Title (Please provide full description):	
Date of Hire (mm/dd/yy):	Number of Hours Worked per Week:	Requested Effective Date (mm/dd/yy):

Section 2-B: Dependent Information (Complete below only if enrolling dependents)

Relationship:	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Relationship: **Spouse**	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Relationship: **Child**	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Relationship: **Child**	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Relationship:	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:
Relationship:	Last Name:	First Name:	Date of Birth (mm/dd/yy):	Gender: Male ◯ Female ◯	Country of Residence:	Height / Weight: m / feet: lbs / kgs:

Section 2-C: Travel Pattern

Anticipated travel pattern for the next 12 months.

Destination	Frequency	Duration	Duties

Section 3-A: Medical Questionnaire: Please complete for all members applying for coverage.

1) Within the past 10 years, have you or any dependent been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following?		
1A) Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system?	Yes	No
1B) Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counselling or therapy?	Yes	No
1C) 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? If yes, most recent blood pressure reading _____. Date recorded _____	Yes	No
1D) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	Yes	No
1E) 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
1F) Cancer, tumour, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder?	Yes	No
1G) Disease or disorder of the breast; kidney; kidney stones; bladder; prostrate; abnormal PSA, or any other urinary disorder or infection?	Yes	No
1H) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear?	Yes	No
1I) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	Yes	No
1J) 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?	Yes	No
1K) Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state Type _____ and most recent blood sugar reading _____. Date recorded _____	Yes	No
1L) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder?	Yes	No
1M) Alcoholism; alcohol, drug or substance abuse or dependency?	Yes	No
1N) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	Yes	No
2) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed?	Yes	No
3) Are you currently pregnant?	Yes	No
3A) If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy? Expected Due Date:	Yes	No
3B) Is this pregnancy the result of infertility treatment?	Yes	No
4) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	Yes	No
5) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	Yes	No
6) Have you been hospitalized in the last 10 years for any reason?	Yes	No
7) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above?	Yes	No
8) Do you engage in any profession, sport, or hobby that could be considered hazardous?	Yes	No
9) Do you receive any disability pension or work accident pension?	Yes	No

Section 3-B: Medical Questionnaire: Give details of each item answered "Yes" in Section 2-A.

(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	On-going or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

Section 3-C: Medication: List all medications that are currently prescribed for you or a family member.

Member Name	Medication Name	Dosage	Frequency	Reason For Use

Section 4: Medical Practitioner: Please provide details of your family Doctor, if you have one.

Name:	Mailing Address:	Phone Number:

Section 5: Beneficiary Information: 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 6: Representations, Acknowledgements, and Authorizations

I, the Undersigned Hereby:

1. Declare that the foregoing answers to the best of my knowledge and belief are true and accurate and are offered as an inducement to grant insurance.
2. 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.
3. Agree that there shall be no insurance until the Insurer has approved this application.
4. Authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.
5. Understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.
6. **Residence Declaration:** I certify that I am not a resident of the United States (living no more than 90 days per year in the U.S.). This policy is not intended for residents of the U.S. 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

_____ _____

Applicant Signature Date Signed

Fax finished application to +949-457-3116 or Email to enroll@gbg.com