



EXPATRIATE HEALTH INSURANCE PLAN

APPLICATION FORM – For people residing outside their Home Country

DAVID CUMMINGS INSURANCE SERVICES LTD.

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[Applications for insurance are subject to approval by the Insurer].

Eff. April 2011

SECTION 1- APPLICANT INFORMATION:

Applicant Name (please print)		Date of Birth	Age	Sex
Last	First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female

Current Address

Street _____ Apt/Unit # _____

City _____ State/Prov _____ Postal Code _____ Country _____

Telephone: (_____) _____ Fax: (_____) _____ E-Mail: _____

Mail Forwarding Address / International Location (if different from above)

Street _____ Apt/Unit # _____

City _____ State/Prov _____ Postal Code _____ Country _____

Telephone: (_____) _____ Fax: (_____) _____


Home Country _____

Home Country wherever used in the Policy means the country for which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the country that the Insured Person has declared on the Application Form. Where a family is to be covered by the Policy, there will be deemed to be one Home Country for that family, which will be the Home Country declared on the Application Form. Coverage in Home Country shall be limited to a maximum period of 90-consecutive Days per trip back in the Home Country and provides for Emergency medical care only unless pre-approved.

Primary Location of Foreign Residency: (Wherever used in the Policy, means the location outside the Insured Person's Home Country where the majority of the Policy Period is spent). This designation will apply to all persons listed in Section 2 of this application.

City _____ State/Prov _____

Country _____

 **Are you a commercial airline pilot or other on board personnel?** If yes, indicate your role and Airline employer(s).

Pilot Other on Board Personnel

Airline: _____

If you, (and/or eligible dependents to be insured with you) pilot or fly as a passenger in **private aircraft**, be sure to give full details in answer to Question 10 on your Underwriting Questionnaire. The premium for the optional AD&D benefit is higher for Airline Personnel.

Effective Date Requested: _____ MM / DD / YYYY	Total Months of Coverage (1 - 12)
Coverage will commence on the date that this application is approved by the Insurance Company or on the Effective Date Requested, whichever is later.	

SECTION 2- SPOUSE & DEPENDANT CHILDREN TO BE INSURED WITH THE PRIMARY APPLICANT

To be eligible, Dependent children must be aged 15 days to 18 years (or up to 24 years if enrolled in full time education) & residing outside their Home Country.

1	Name (please print)	Date of Birth	Age	Sex
	Last First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Country:			
2	Name (please print)	Date of Birth	Age	Sex
	Last First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Country:			
3	Name (please print)	Date of Birth	Age	Sex
	Last First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Country:			
4	Name (please print)	Date of Birth	Age	Sex
	Last First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Country:			
5	Name (please print)	Date of Birth	Age	Sex
	Last First	MM / DD / YY		<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Country:			

SECTION 3 – UNDERWRITING QUESTIONNAIRE – Must be completed by each person to be insured.

1. a) Height _____ m _____ ft
 b) Weight _____ kg _____ lbs.
2. Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:
- | | No | Yes |
|--|--------------------------|--------------------------|
| a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) asthma, chronic cough, shortness of breath, or convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| c) high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) ulcer, liver disorder, colitis, chronic diarrhea, | <input type="checkbox"/> | <input type="checkbox"/> |
| f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| g) cancer, tumor, leukemia, enlarged glands or lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) diabetes, sugar in urine or thyroid disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| i) urine, kidney or bladder disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| j) anemia, bleeding or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| k) difficulty with eyes or ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) | <input type="checkbox"/> | <input type="checkbox"/> |
| m) a positive HIV (Human Immune Deficiency Syndrome) test? | <input type="checkbox"/> | <input type="checkbox"/> |
3. a) Indicate your average weekly consumption of alcohol
 Beer _____ oz. Wine _____ oz. Liquor _____ oz.
 b) Have you ever been advised to stop drinking alcohol or to drink less? No Yes
4. a) Have you ever been refused life or health insurance or been offered it on special terms? No Yes
 b) If you have recently applied for another insurance Policy, please provide:
 Date: _____ Policy No. _____
 Name of Insurance Company: _____
5. Do you have an annual checkup No Yes
 If “Yes” provide results: _____

 If “No” provide date and results of last check up.
 Date: _____ Results: _____
6. In the past five years have you:
 a) except for annual check-ups, consulted a Physician, had surgery or been treated in a hospital? No Yes
 b) received or applied for disability benefits for three months or longer? No Yes
 c) had a urinary tract infection or any sexually transmitted disease? No Yes
7. Within the past twelve months, have:
 a) your duties been modified due to health reasons? No Yes
 b) you been off work for more than five consecutive days due to illness or injury? No Yes
 c) you used tobacco products? No Yes
 If “Yes”, indicate the number per day _____
8. Within the past ten years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, except as prescribed by a physician? No Yes
9. Are you presently under medical treatment by diet, medicine, or other means? No Yes
10. Do you engage in any of the following activities: mountaineering, scuba diving, rock or precipice climbing, hang gliding, paragliding, sport parachuting, sky diving, athletic or sports activities for remuneration or prize money, vehicle or boat racing, or aviation except as a passenger? No Yes
11. a) For women: are you pregnant? No Yes
 b) Have you ever had any complications of pregnancy? No Yes
12. In the past twelve (12) months have you experienced any symptoms that you have not yet sought medical treatment for? No Yes

Please note:
 The Underwriter reserves the right to request additional information.

For each “Yes” answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

Authorization

I certify that the above statements and those on any attached sheet are true and complete. I authorize Norfolk Mobility Benefits Inc. and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for Norfolk Mobility Benefits Inc., to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy of this authorization is as valid as the original.

Date: _____ Signature of Applicant _____

The applicant must initial any corrections made on the application. You should keep a copy of this Questionnaire for your records.

***A Medical Questionnaire must be completed for each person to be insured.**

SECTION 4 – Selection of Annual Deductible & Optional Benefits

I select the following Policy Currency (This determines the currency of your benefits and for claim reimbursement):

US Dollars

Canadian Dollars (Only available to applicants whose Primary Location of Foreign Residency is Canada)

I select the following Annual Deductible amount: The deductible you select will apply **per family member, per Policy Year**

\$0 (Plan A) \$500 (Plan B) \$1,000 (Plan C) \$5,000 (Plan D) \$10,000 (Plan E) \$25,000 (Plan F)

I select the following Co-Insurance Class for the Major Medical Benefit:

Class 1 – 100% Reimbursement on **Out-Patient** Services including Diagnostics, and
100% Reimbursement on **In-Patient** (Hospitalization) Services

Class 2 – 80% Reimbursement on all **Out-Patient** Services including Diagnostics,
100% Reimbursement on **In-Patient** (Hospitalization) Services

I select the following Optional Benefit(s): Leave blank if none required

* Indicates benefits available only in addition to a medical plan. Once in effect, these optional benefits cannot be cancelled for a refund of premium. However, they may be removed from your insurance policy at the next policy renewal.

<input type="checkbox"/>	*Maternity/Newborn Benefit: (only available for policies that are 6 months or more in length) Coverage will not apply where the expected date of childbirth is less than ten (10) months from the Insured Person's original effective date of this option.
<input type="checkbox"/>	*Dental Option 1 (only available for policies that are 6 months or more in length) 60% Basic / Preventative and 50% Major / Restorative up to combined max. of \$2000 + 50% Orthodontics up to \$2,000 lifetime max
<input type="checkbox"/>	*Dental Option 2 (only available for policies that are 6 months or more in length) 80% Basic / Preventative and 50% Major / Restorative up to combined max. of \$2000 + 50% Orthodontics up to \$2,000 lifetime max
<input type="checkbox"/>	Accidental Death & Disablement Insurance in the amount of \$_____ The principal sum insured for primary insured can be any multiple of \$1,000 up to a maximum of \$250,000. A dependent spouse can be insured to an amount equal or less than that of the primary. Dependent children can be insured to \$10,000. For AD&D coverage for spouses and dependents, please see Dependent AD&D Application Form. Beneficiary Designation:
	Last name: _____ First name(s): _____
	Date of Birth (mm/dd/yyyy) _____ Relationship to Applicant _____
	Beneficiary's Country of Residence _____

The following benefits are available if you are under age 65, and are **employed and working** outside of your home country.

Disability Insurance – a separate application form will be issued to you for this option.

Life Insurance - a separate application form will be issued to you for this option.



Expatriate Health Insurance Plan – Cost Calculation & Payment

* If you selected a US Dollar Policy use the USD Rate Table
 If you selected a Canadian Dollar Policy use the CAD Rate Table

* All applications are subject to underwriting approval and underwriting surcharges may apply. If an underwriting surcharge is required by the Insurer you will be advised of this prior to any charges being transacted, and you will be asked to confirm your acceptance of the additional premium.

SECTION 7 – Cost Calculation Worksheet

1. Total Base Medical Premium:	\$
2. MEDEX Premium:	\$
3. Underwriting Surcharge: (If applicable)	\$
4. Optional Benefits Premium: (If applicable)	\$
5. Add \$50 admin fee IF applying for 5 or less months duration	\$
6. Sub-Total:	\$
7. Method of Payment: The monthly payment option is only available on policies of 12 months.	<input type="checkbox"/> Total Up Front <input type="checkbox"/> Monthly Payments
8. 12% surcharge for monthly payments: (if applicable)	\$
9. Adjusted Sub-Total (Same amount as line 6 if paying up front)	\$
10. 2.5% surcharge for credit card payment or \$15 for wire transfer: Enter '0' if paying by cheque	\$
11. Grand Total: (Same as line 9 if paying by cheque)	\$

SECTION 8 – PAYMENT, AUTHORIZATION & SIGNATURE (\$50 fee applies to all eligible refund requests)

Please select your method of payment. *Note: Please make cheques payable to 'David Cummings Insurance Services Ltd.'*

Cheque / Money Order Cash (do not mail cash) Wire Transfer (+ \$15 to premium) Visa / MasterCard (+ 2.5% to premium)

Credit Card Number

Name on Credit Card _____ Credit Card Expiry Date ____/____/____
MM YY

Credit Card Authorization: Please check one box only.

I authorize David Cummings Insurance Services Ltd. to charge my Credit Card for the Total Policy Premium as confirmed by David Cummings Insurance Services Ltd.

I authorize David Cummings Insurance Services Ltd. to charge my Credit Card for the confirmed Monthly Installment amount (as confirmed by David Cummings Insurance Services Ltd) until the Total Policy Premium has been paid.

APPLICATION DATE

PRINT Applicant's Name

SIGNATURE of Applicant

_____/_____/_____
MM DD YYYY