



EXPATRIATE HEALTH INSURANCE PLAN

APPLICATION #1 – For expatriates residing outside Canada.

DAVID CUMMINGS INSURANCE SERVICES LTD.

350 - 2083 Alma St., Vancouver, B.C. V6R 4N6, Canada

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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.

This insurance plan is not available to US citizens residing in the USA, even those who also hold a passport / citizenship from another country.

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 _____

Effective Date Requested: _____ MM / DD / YY	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 INFORMATION – Only include if coverage is required

Please Note: Dependiant children aged 15 days to 18 years (or up to 24 years if enrolled in full time education).

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

Applicant Name _____

SECTION 3 – MEDICAL QUESTIONNAIRE – Must also be completed by Spouse and each Dependant child

1. a) Height _____ m _____ ft No Yes
 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?

4. a) Have you ever been refused life or health insurance or been offered it on special terms?
 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
 If “Yes” provide results: _____

 If “No” provide date and results of last check up.
 Date: _____ Results: _____

6. In the past 5 years have you:
 a) except for annual check-ups, consulted a Physician, had surgery or been treated in a hospital?
 b) received or applied for disability benefits for 3 months or longer?
 c) had a urinary tract infection or any sexually transmitted disease?

7. Within the past 12 months, have:
 a) your duties been modified due to health reasons?
 b) you been off work for more than 5 consecutive days due to illness or injury?
 c) you used tobacco products?
 If “Yes”, indicate the number per day _____

8. Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician?

9. Are you presently under medical treatment by diet, Medicine, or other means?

10. Do you engage in any of the following activities: Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger?

11. a) For women: are you pregnant?
 b) Have you ever had any complications of pregnancy?

12. In the past 6 months have you experienced any symptoms that you have not yet sought medical treatment for?

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 Health Questionnaire for your records.

This Policy is Underwritten by Various Syndicates at Lloyds

SECTION 4 – IMPORTANT NOTE**PLEASE NOTE**

This application does not detail all the policy terms and conditions of the policy wording. The terms and conditions of the coverage you are applying for are available for your reading. You are responsible to read the terms and conditions and are welcome to contact us with any questions you have.

SECTION 5 – Selection of Annual Deductible & Optional Benefits**I select the following Annual Deductible amount.**

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

Please select the extra benefit(s) that you require.

* 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 can be any multiple of \$1,000 up to a maximum of \$250,000.
	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 **working** outside of your home country.

<input type="checkbox"/>	Disability Insurance – a separate application form will be issued to you for this option.
<input type="checkbox"/>	Life Insurance - a separate application form will be issued to you for this option.

SECTION 6 – RATES in US Dollars

Are you an airline pilot or other airline personnel? Yes No (Rates for AD&D coverage are higher for Airline Personnel)
If yes, indicate Name of Airline Employer(s) _____

If you, and/or eligible dependents to be insured with you, pilot or fly in private aircraft, be sure to give full details with your medical questionnaire in answer to question 10.

Rates effective April 1 2010 through March 31 2011

Family Medical Premium: The family rate is **2.5** times the individual premium of the oldest family member, plus the premium for any additional benefits elected. The deductible you select will apply **per family member**. Eligible dependents for the family premium include the legal spouse of the primary insured person, and dependent children aged 15 days to 18 years (or to age 24 years with written proof of enrollment in full time education).

USD Rate Table 1 - Medical Plan Monthly Rates in US Dollars

AGE	Plan A \$0 Deductible	Plan B \$500 Deductible	Plan C \$1000 Deductible	Plan D \$5000 Deductible	Plan E \$10,000 Deductible	Plan F \$25,000 Deductible
up to 39	284	271	258	199	176 **	161 **
40-54	299	284	269	199	176 **	161 **
55-59	519	493	467	342	305 **	280 **
60-64	650	618	585	434	383 **	351 **
*65-69	X	X	X	1354	965	884
*70-80	X	X	X	1935	1361	1247

* Rates for ages 65+ only apply to existing members who qualify for renewal. If insured for a minimum of two (2) continuous years prior to age 65, members may renew under Plan Options D, E, and F to age 80, **with annual medical qualifying after age 70.**

** Under Medical Plans E and F only, prices marked with “ ** ” include Gross Premium set by the Insurers, plus a 7% broker services fee retained by DCIS.

Optional Benefits Rate Table

Monthly Rates in US Dollars

Annual Rates in US Dollars

Maternity / Newborn Benefit	\$273	\$3276
Dental Care Option 1	Single \$97 Couple \$146 Family \$182	Single \$1,164 Couple \$1,752 Family \$2,184
Dental Care Option 2	Single \$119 Couple \$180 Family \$225	Single \$1,428 Couple \$2,160 Family \$2,700
Accidental Death & Disablement Insurance	\$0.12 per \$1,000 of coverage per person	\$1.44 per \$1,000 of coverage per person
Accidental Death & Disablement Insurance for Airline Personnel	\$0.62 per \$1,000 of coverage per person	\$7.44 per \$1,000 of coverage per person

SECTION 7 – COST CALCULATION - All applications are subject to underwriting approval and underwriting surcharges may apply.

1. Total Base Medical Premium:	\$
2. Total Underwriting Surcharge:	\$
3. Total Optional Benefits Premium:	\$
4. add a flat \$50 admin fee on policies of 1 - 5 months duration	
5. Policy Premium:	\$
6. Method of Payment: The monthly payment option is only available on policies of 6 – 12 months.	<input type="checkbox"/> Total Up Front <input type="checkbox"/> Monthly Credit Card Payments
7. 12% surcharge for monthly payments:	\$
8. Adjusted Policy Premium: (if applicable)	\$
9. 2.5% surcharge for credit card payment or \$35 for wire transfer:	\$
10. Total:	\$

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 (+ \$35 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 YY