Application for **Individual Health Insurance**

VUMI

(195104) West Coast Global Insurance (818) 788-5353 Service@WestCoastRi.com

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, Access VIP, Prime VIP
3. Option: I, II, III, IV, V, VI
4. Additional coverage:

Maternity and newborn complications

Organ transplant

Life term insurance — Applicant — Spouse / Domestic partner

Name of the beneficiary and relationship to the applicant:

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's full name:

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's full name:

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's full name:

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's full name: 3. Illness or injury:

4. From M M / D D / Y Y Y Y

5. To: M M / D D / Y Y Y Y

6. Physician's name:

7. Physician's phone number: + - -

8. Treatment, results and current condition:

MEDICAL CONDITION 2

1. Number: 2. Applicant's full name: 3. Illness or injury:

4. From M M / D D / Y Y Y Y

5. To: M M / D D / Y Y Y Y

6. Physician's name:

7. Physician's phone number: + - -

8. Treatment, results and current condition:

MEDICAL CONDITION 3

1. Number: 2. Applicant's full name: 3. Illness or injury:

4. From M M / D D / Y Y Y Y

5. To: M M / D D / Y Y Y Y

6. Physician's name:

7. Physician's phone number: + - -

8. Treatment, results and current condition:

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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's full name:
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's full name:
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's full name:
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's full name:
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's full name:
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's full name:
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:

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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's full name:

2. Relationship to the applicant:

3. Disease:

FAMILY HISTORY 2

1. Applicant's full name:

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 full name:

2. Applicant's signature:

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

4. Spouse's full 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 full name: Jason Wagner (WC Global Insurance)

195104

8. Agent's signature: Jason Wagner

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

Section VIII. **Payment** Information

(payment must be submitted with the application)

1. Applicant's full name:

2. Policy number:

3. Payment frequency:

- Annual
- Semi-annual
- Quarterly

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

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

Payment method OPTION 1:

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

Payment method OPTION 2:

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: + ___ - ___ - ______

Bank Account

1. Bank account holder's full name:

2. Bank Account number: ____-____-____-____

3. ABA/routing number:

4. Amount to charge: US$

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

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

7. Cardholder's / Bank account holder adress (where statement is received):

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 accept 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 / Bank account holder's signature: