

TheInsuranceNet.com

Instructions for applying for Immigrant health insurance

- 1) Print out application.**
- 2) Fill out application completely.**
- 3) If paying by credit card, fax back to 410-796-7456 (24 hr fax)* or call our office to enroll by phone.**
- 4) If paying by check or money order, make it payable to “SRI” and mail to....**

**TheInsuranceNet.com
5965 Sandy Ridge
Elkridge, MD 21075**

- 5) Call with questions 410-796-7497 or toll free 877-634-1256.**



APPLICATION FOR COVERAGE

RESIDE Prime Worldwide Medical Plan
(formerly the Signature Worldwide Medical Plan)
The Mega Life & Health Insurance Company

As described in the brochure and documentation, RESIDE Prime Worldwide Medical Plan is a comprehensive medical insurance program designed exclusively for the international citizen. In order to provide you and your family with the coverage you desire, please follow the directions and answer all questions in complete detail.

Please note that RESIDE Prime limits coverage in the United States to 6 months during any given 12 month policy period. This plan is not intended to cover permanent residents of the United States.

DIRECTIONS FOR COMPLETING THE APPLICATION:

1. Please print or type all information. Illegible information will delay underwriting and processing of your coverage.
2. Each family member requesting coverage must be listed on the Application. All questions on the Application apply to all applicants requesting coverage. Answer each and every question, as it pertains to each applicant listed on the Application. All members of a family must choose the same Deductible.
3. Each section of the application must be completed in full. Any question where a "YES" was marked must be described in detail in Section 3. Information in Section 3 must include the applicant's name, physician's name, address and phone number, address of treating facility, diagnosis, prognosis, and course of treatment. If necessary, use an additional sheet of paper to describe the condition(s) and attach it to the Application when submitted to SRI.
4. The Premiums listed on the enclosed rate card are annual premiums and can be paid by check, money order, VISA or MasterCard. **Due to the questionable reliability of international mail, monthly, quarterly and semi-annual payments can only be made by using a credit card.** Monthly, quarterly and semi-annual payment modes are only accepted with preauthorization to debit your credit card on the due date of your premium installment.
5. Once SRI underwrites your application and determines that coverage should be issued, we will send you an ID Card and a Certificate of Coverage by mail. The Certificate of Coverage contains the full program wording and definitions. This package will also include details on how to submit a claim as well as information regarding SRI's Utilization Management (U.M.) Program.

All Sections Must Be Completed in Full

SECTION 1. APPLICANT INFORMATION:

Applicant's Name (Last, First, Middle, Maiden)	Sex	Relationship	Date of Birth (Mo/Day/Yr)	Birthplace State/Country	Height Feet / Inches	Weight lbs	Premium
		Primary					
		Spouse					
		Child					
		Child					
		Child					
Total:							
Residence Address: (street, city, state, country, postal code):							
Mailing Address: (street, city, state, country, postal code):							
Home Phone:			Business Phone:				
Fax:			E-Mail Address:				
Occupation of Primary Insured:			Occupation of Spouse:				
Previous Occupation:			Name of Employer:				
Single or Married (please circle)							
If you are a US citizen: When do you plan to depart the US? ____ / ____ / ____ (month/day/year)							
How long do you plan to reside outside of the US during a given year? (If you spend more then 6 months in the U.S., this insurance will not be valid)							
How many years do you intend to have this plan?							
Are all listed dependents who are age 19, 20, 21, 22. and 23 full time students? (yes, please list schools and location)							(if

SECTION 2. HEALTH HISTORY QUESTIONS FOR APPLICANTS

In order for your Application to be processed successfully, each question must be answered truthfully. Any answers to "yes" questions must be clarified in Section 3 Health History Details below. SRI may ask for additional information once the Application is received.		
1. Within the past 5 years, have you or any applicant ever had, been medically advised that you've had, been referred for counseling or treatment, surgery or been treated for:	Yes	No
(a) any disease or disorder of the heart, muscles, or colon; cancer, leukemia, diabetes, paralysis or stroke?		
(b) any immune disorders, AIDS, sexually transmitted diseases, chronic lung disorders, Kaposi's sarcoma?		
(c) a positive test for HIV?		
(d) any nervous, mental or behavioral disorder, alcoholism, or chemical alcohol, or drug abuse or addiction, or has any applicant used illegal drugs or used prescription medication, other than as prescribed?		
2. Have you or any applicant ever been rejected, ridered or premium increased for any other Health, Life or Disability Policy?		
3. Are you or any applicant currently hospitalized, disabled or unable to perform normal activities?		
4. Are you or any applicant currently taking any prescribed medication, or under medical treatment, or have you been advised of the possibility or necessity of further treatment or surgery for any condition?		
5. For female applicants, are you currently pregnant? If yes, due date: _____		
6. Have you or any applicant ever been treated or diagnosed with any reproductive system disorders?		
7. Within the past 5 years, have you or any applicant ever had, been medically advised that you have had, or been treated for: (Please circle all of the following that apply.)	Yes	No
(a) a disease or disorder of the kidneys, urinary tract, digestive system, reproductive system, liver, lungs, back bones, or joints?		
(b) high blood pressure, chest pain, seizure disorder, rheumatic fever, heart murmur, tuberculosis, or hepatitis?		
(c) cancer, tumor, cyst, polyp or other growth, thyroid disorder, or arthritis?		
(d) any other physical disorder or deformity?		
8. Have you or any applicant, or do you or any applicant currently use any form of tobacco? If so, in which form(s), quantity and how often? _____		
9. Within the past 3 years, have you or any applicant: (Please check all of the following that apply.)	Yes	No
(a) consulted any doctor, counselor or therapist?		
(b) been hospitalized or undergone medical studies including laboratory or radiological testing?		

SECTION 3. HEALTH HISTORY DETAILS FOR APPLICANTS

List details for all "YES" answers to the Section 2 health history questions (use additional paper, if necessary). Incomplete answers may delay processing.

Name of Person and Question #	Condition / Diagnosis, Treatment Medication Prescribed and Results of Treatment	Dates Seen & Duration	Physician / Clinic Address and Telephone #

Information about prior / other coverage

		Yes	No
1. Have you been covered by another medical plan at any time during the past year?			
2. Will you be covered under any other medical plan (individual or group) while you are covered under this plan?			
3. For all "YES" answers, please provide the following information. If more than one situation applies, attach a separate piece of paper to describe each situation.			
Name of Insured(s):	Policy / certificate number:		
Type of plan (please circle):	Spouse's employer group plan	Other group plan	Individual Plan
Insurance Company Name:	Phone:		
Coverage effective date:	If applicable, termination date:		
Reason for termination:	Left employment	Employer canceled plan	Non-Renewal

SECTION 4. DECLARATION AND ENROLLMENT REQUEST / AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I represent that all information on this Application and any attachments hereto is complete and true to the best of my knowledge and belief. I understand that The MEGA Life and Health Insurance Company will rely on all information on this Application in determining whether or not to issue coverage and that any incorrect or incomplete information may void this insurance.

I hereby request to enroll under the Global International Trust, Washington, DC. In this request, all elections and authorizations shall remain in effect until I change them in writing.

I understand that health benefits may be limited or excluded for conditions for which any insured person has received any medical diagnosis or treatment, or taken any medication, before his or her effective date, according to the pre-existing conditions limitations provisions of the plan.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my dependents to give to The MEGA Life and Health Insurance Company or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about: (1) physical condition(s), (2) health history(ies), (3) avocation(s), (4) age(s), (5) occupation(s), and (6) personal characteristics. This authorization includes information about (1) drugs, (2) alcoholism, (3) mental illness, or (4) communicable diseases.

I UNDERSTAND the information obtained by use of this Authorization will be used by The MEGA Life and Health Insurance Company to determine eligibility for benefits. I ALSO AUTHORIZE The MEGA Life and Health Insurance Company to release any information obtained to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may

be otherwise lawfully required, or as I may further authorize.

I AGREE this Authorization shall be valid for two and one-half years from the date shown below. I KNOW that I may request to receive a copy of this Authorization. I also acknowledge that I have read IMPORTANT NOTICES 1, 2, 3, 4 and 5 that have been given to me. I AGREE that a copy of this Authorization shall be as valid as the original.

I UNDERSTAND that as a resident of a foreign jurisdiction, I may be subject to foreign laws with respect to the type and form of coverage in which I am enrolling. I also understand and agree that responsibility for complying with those foreign laws rests solely on me.

I UNDERSTAND that effective dates will be in accordance with the terms of the applicable effective date and acceptance by SRI. I also UNDERSTAND that coverage in the United States is limited to 6 months during any one 12 month policy period.

I ALSO UNDERSTAND any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF PROPOSED INSURED OR GUARDIAN: _____ Date: _____

SIGNATURE OF PROPOSED INSURED's SPOUSE (if applicable): _____ Date: _____

SECTION 5. PROGRAM SPECIFICS

Please Circle Your Chosen Deductible: \$500 \$1000 \$2500 \$5000				
Requested Effective Date: ____ / ____ / ____ (month/day/year) (Effective date must be within 60 days of application date)				
For the AD&D benefit, the Primary Insured shall be the beneficiary of the certificate. If the benefit is utilized for the Primary Insured, his/her estate shall be the beneficiary. If this is not acceptable, please list the beneficiary:				

PREMIUM CALCULATION AND PAYMENT

Annual Premium for all applicants: _____	Premium Installment	Factors
Installment Factor (from right): X _____	Annual	1.00
(Checks are only acceptable for annual payments)	Semi-Annual	.55
Total Premium Submitted: =	Quarterly	.28
_____	Monthly	.10
	Important: Checks accepted for Annual Premium ONLY.	

METHOD OF PAYMENT**Method of Payment**

Check Money Order MasterCard Visa Card# _____ Expiration Date:

Name as it appears on credit card: _____ Daytime phone:

Signature:

Billing Address:

All premium payments must be made in U.S. dollars. Checks must be issued from a U.S. bank and made payable to "SRI". If paying by credit card, I authorize SRI to debit by Visa/MasterCard account for the total amount due. In the event that I have elected to *Pre-Authorize credit card payment installments, I hereby request and authorize SRI to debit my credit card periodically as payment installments become due. This authorization will remain in effect until revoked by me in writing, and until SRI actually receives notice. Coverage purchased by credit card is subject to validation and acceptance by credit card company. *For any installment payment other than annual, I pre-authorize SRI to debit my credit card for the proper installment amount on the due date of the installment. _____ (Sign here for Pre-Authorization of Installment Premiums)

AGENT INFORMATION

SRI Agent# _3366_____ Agent Name: J. Motsco

Company Name:

_TheInsuranceNet.com_____

Address:

_5965 Sandy Ridge_____

City: ___Elkridge_____ State: ___MD_____ Zip: 21075

Phone: _410-796-7497 or 877-634-1256 toll-free in US_____ Fax: 410-796-7456_____

To the best of my knowledge, the application is truthful and accurate.

Agent's Signature: _____

Please mail or fax to:

TheInsuranceNet.com

5965 Sandy Ridge

Elkridge, MD 21075

Fax: 410-796-7456

Underwritten by:

The MEGA Life and Health Insurance Company, Rated A- "Excellent" by AM Best

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(formerly Signature Worldwide Medical Plan)

Annual Premiums Effective January 1, 2001

Underwritten by: The MEGA Life and Health Insurance Company

Age	If you choose a \$500 Annual Deductible		If you choose a \$1000 Annual Deductible		If you choose a \$2500 Annual Deductible		If you choose a \$5000 Annual Deductible	
	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>	<u>Male</u>	<u>Female</u>
14 days through 18	\$510	\$510	\$420	\$420	\$391	\$391	\$368	\$368
19 through 29	\$1,002	\$1,746	\$778	\$1,351	\$679	\$1,179	\$533	\$920
30 through 39	\$1,164	\$2,086	\$902	\$1,612	\$789	\$1,407	\$618	\$1,098
40 through 44	\$1,334	\$1,675	\$1,033	\$1,296	\$902	\$1,131	\$740	\$941
45 through 49	\$1,470	\$1,838	\$1,138	\$1,421	\$993	\$1,240	\$810	\$978
50 through 54	\$1,801	\$2,011	\$1,392	\$1,560	\$1,215	\$1,389	\$1,030	\$1,152
55 through 59	\$2,210	\$2,210	\$1,710	\$1,708	\$1,490	\$1,490	\$1,255	\$1,267
60 through 64	\$3,025	\$2,830	\$2,550	\$2,251	\$2,310	\$2,072	\$1,930	\$1,715
65 through 69	\$6,521	\$5,653	\$6,100	\$5,149	\$4,690	\$3,827	\$4,100	\$3,672
70	\$7,805	\$6,674	\$7,200	\$6,158	\$5,700	\$4,660	\$4,503	\$3,738
71	\$8,150	\$6,988	\$7,604	\$6,473	\$6,007	\$4,869	\$4,805	\$3,895
72	\$8,535	\$7,327	\$8,034	\$6,853	\$6,342	\$5,147	\$5,073	\$4,119
73	\$8,972	\$7,681	\$8,432	\$7,186	\$6,667	\$5,438	\$5,330	\$4,365
74	\$9,385	\$8,081	\$8,875	\$7,559	\$7,022	\$5,724	\$5,623	\$4,575

Dependent Child*	\$410	\$410	\$321	\$321	\$281	\$281	\$258	\$258
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* The Dependent Child Premium is only available when one parent (legal guardian), of a natural or legally adopted unmarried child over 14 days old and under 19 years of age (or under 24 years of age if attending a university full-time and must rely on parents for support), is also covered under the same program. No premium is charged for the first two (2) Dependent Children between the ages of 14 days and 9 years old if both parents are also covered under the same program.

If the Applicant desires to pay premiums on a Semi-Annual, Quarterly or Monthly basis, they must do so by Visa or Master Card payment only. SRI will automatically debit the credit card on the due date of the premium installment. The Premium Installment Factors to be applied to the Annual Premium are as follows:

Annual = 1.00 Semi-Annual = .55 Quarterly = .28 Monthly = .10

IMPORTANT NOTICE: The premiums referenced above are applicable for the initial 12 month coverage period, only after the Applicant has been accepted by SRI. SRI reserves the right to increase the stated premiums based upon the Applicant's medical condition at the time of application and underwriting. Applicants with chronic and/or severe medical conditions may be declined. At each renewal period, SRI will inform the Applicant of the renewal premium for each subsequent coverage period based upon the Applicant's age and deductible category.

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