TheInsuranceNet.com

Instructions for applying for Immigrant health insurance

1) Print out application.

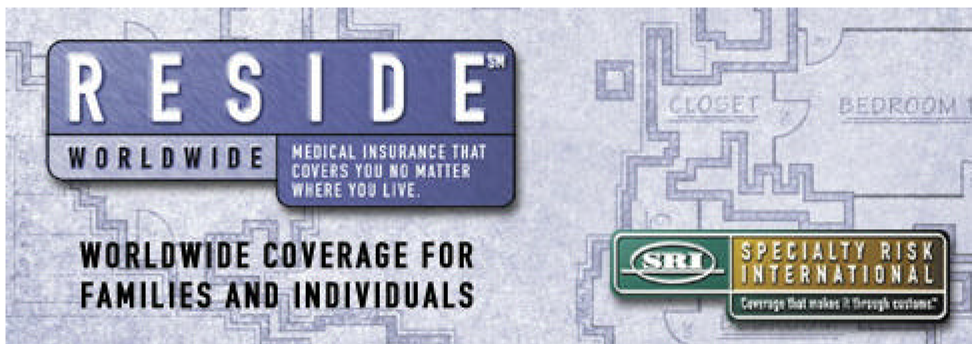
2) Fill out application completely.

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.



RESIDE APPLICATION

As described in the brochure and documentation, RESIDE 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**.**

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 are annual premiums and can be paid by check, money order, VISA, MasterCard, Diners Club, American Express, or Discover. **Due to the inconsistent reliability of international mail, monthly, quarterly and semi-annual payments can only be made by using a credit card or ACH payment.** Monthly, quarterly and semi-annual payment modes are only accepted with preauthorization to debit your credit card or checking account 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 concerning procedures for claims submission and the importance of SRI's pre-notification procedures.

All Sections Must Be Completed in Full

SECTION 1. APPLICANT INFORMATION:

Applicant's Name (Last, First, Middle, Maiden)	Sex M/F	Relationship	Date of Birth (Mo/Day/Yr)	Citizenship Country	Height Feet / Inches	Weight lbs	Premium
		Primary					
		Spouse					
		Child					
		Child					
		Child					
						Total:	

Address of Residence: (must be outside the United States) (include street, city, state, country, postal code):	
Forwarding / Convenience Address: (include street, city, state, country, postal code):	

Home Phone: Fax:	Business Phone: E-Mail Address:
Occupation of Primary Insured:	Occupation of Spouse:
Previous Occupation: (previous 2 years)	Name of Employer: (if retired, previous occupations)
Single or Married (please circle)	
If you are a US citizen or currently in the US: When do you plan to depart the US? _____ / _____ / _____ (month/day/year)	
Length of time per year outside the United States?	
Where are you traveling?	
How long do you require coverage under Reside?	
Is your primary language English?	If not, what is your primary language?

SECTION 2. HEALTH HISTORY QUESTIONS FOR APPLICANTS

For your own protection it is important that 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 10 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 (please check all of the following that apply):	Yes	No
(a) any disease or disorder of the heart, muscles, or colon; cancer, leukemia, diabetes, paralysis or stroke?		
(b) any disease of the circulatory, nervous, muscular, skeletal, or respiratory systems?		
(c) any immune disorders, AIDS, sexually transmitted diseases, chronic lung disorders, Kaposi's sarcoma?		
(d) a positive test for HIV?		
(e) 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, or within the last 12 months, 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 or have you ever had a complicated pregnancy or delivery? If currently pregnant, due date: _______________		
6. Have you or any applicant ever been treated or diagnosed with any reproductive system disorders?		
7. Within the past 10 years, have you or any applicant ever had, been medically advised that you have had, or been treated for: (Please check all of the following that apply.)	Yes	No
(a) a disease or disorder of the kidneys, urinary tract, digestive system, gall bladder, pancreas, liver, lungs, back bones, spine or joints?		
(b) high blood pressure, chest pain, headaches, seizure disorder, rheumatic fever, heart murmur, tuberculosis, or hepatitis?		
(c) cancer, tumor, cyst, polyp or other growth, thyroid disorder, convulsions, epilepsy, elevated cholesterol 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 5 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, had surgery discussed, or undergone medical studies including laboratory or radiological testing?		
10. Have you or any applicant recently experienced any signs, indications, symptoms, diagnosis or treatment that would cause you to believe that you currently have a new medical condition?		

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 #

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

I hereby apply for the Reside program and for the insurance provided by Certain Underwriters at Lloyds, London.

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 Specialty Risk International, Inc. (the "Administrator") 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 and/or rescind this insurance at any time upon discovery.

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, or realized the manifestation of a condition 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 the Administrator 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 Administrator to determine eligibility for benefits. I ALSO AUTHORIZE the Administrator 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 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 no coverage is effective until I am notified in writing by the Administrator and advised of the official Effective Date. I also UNDERSTAND that if I am not accepted for coverage by the Administrator, the sole obligation of the Administrator and the Underwriter is to return the premium. I also UNDERSTAND that if I am a United States citizen, coverage in the United States is limited to 6 months during any one 12 month policy period. I also UNDERSTAND that Lloyds operates as an approved but non-admitted insurer in most US states and that claims may not be made against any state guarantee fund.

I UNDERSTAND that this program is not, nor does it intend to be, a general United States health insurance policy.

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: $250 $500 $1000 $2500 $5000	
Requested Effective Date: _____ / _____ / _____ (month/day/year) (Requested Effective Date must be within 60 days of application date. If accepted, official Effective Date will be advised by SRI)	
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:		
Installment Factor (from right): (Checks are only acceptable for annual payments)	X	
Total Premium:	=	
Application Fee:	+	
Total Initial Payment:	=	

Premium Installment	**Factors**
Annual	1.00
Semi-Annual	0.55
Quarterly	0.28
Monthly	0.10

Important: Checks accepted for Annual Premium ONLY

METHOD OF PAYMENT

Corporate Check <> Money Order <> Visa <> MasterCard <> Discover / Novus <> American Express <> Diners Club<>

Card #		Expiration Date:	
		Daytime Phone:	
Name as it appears on card:		Signature (Required):	
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 my credit card 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)

Check or money order should be made payable to SRI. All payments must be made in U.S. dollars, from a U.S. Bank, and submitted at the time application for coverage is made.

AGENT INFORMATION

Agent	J. Motsco	SRI Agent	#:3366
Address:	5965 Sandy Ridge	City / State / Zip:	Elkridge, MD 21075
Phone (incl area code):	410-796-7497	Fax (incl area code):	410-796-7456
E-Mail:	info@theinsurancenet.com		

Please mail or fax to:
TheInsuranceNet.com
5965 Sandy Ridge
Elkridge, MD 21075
Fax: 410-796-7456

Underwritter:
Certain Underwriters at Lloyds, London. Rated A "Excellent" by AM Best.

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