Best Doctors® INSURANCE

Application Form

A member of **Now Health International**

Important: Please make sure all the information required on this health insurance application has been provided. Best Doctors Insurance Limited reserves the right to contact the applicant if a question has not been answered in detail or if additional information is needed. Any incomplete applications will be returned to the applicant for more information, delaying the processing of your application.

☐ New application
☐ Change my current plan/deductible
☐ Add dependents
☐ Reinstatement

If change of plan, please indicate name of previous plan

APPLICANT INFORMATION

LAST NAME(S)

FIRST NAME(S)

STREET ADDRESS

GENDER
☐ Male
☐ Female

CITY

COUNTRY

STATUS
☐ Single
☐ Married
☐ Domestic Partnership

EMAIL ADDRESS

TELEPHONE (OFFICE OR MOBILE NUMBER)

FAX

PLACE AND DATE OF BIRTH (MM/DD/YYYY)

HEIGHT ☐ M ☐ FT

WEIGHT ☐ KG ☐ LB

PASSPORT/ID NUMBER (PLEASE PROVIDE COPY OF DOCUMENT)

OCCUPATION

PREMIUM (USD)

SELECT PLAN

SELECT DEDUCTIBLE*

	I	II	III	IV	V	VI
☐ Premier Plus	☐ $ 500 $1,250	☐ $1,000 $2,500	☐ $5,000 $5,000	☐ $10,000 $10,000	☐ $20,000 $20,000	
☐ Global Care	☐ $ 500 $1,000	☐ $2,000 $2,000	☐ $5,000 $5,000	☐ $10,000 $10,000	☐ $20,000 $20,000	
☐ Ultimate Care	☐ $0 $0	☐ $2,500 $2,500	☐ $5,000 $5,000	☐ $10,000 $10,000	☐ $20,000 $20,000	☐ $50,000 $50,000
☐ Advanced Care Plus	☐ $5,000 $5,000	☐ $10,000 $10,000				
☐ Other						

* Deductibles may vary in some regions, please refer to premium tables for correct deductible amounts

ADDITIONAL COVER AVAILABLE (RIDERS)

☐ **CRITICAL SELECT** (If selected, please complete the Critical Select Questionnaire)

☐ Maternity Complications ☐ Organ Transplant

Continued over

DEPENDENT'S INFORMATION AND PREMIUMS

1. FIRST AND LAST NAME(S) _____ PREMIUM (USD) _____

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YYYY) _____ HEIGHT _____ M FT WEIGHT _____ KG LB GENDER M F

2. FIRST AND LAST NAME(S) _____ PREMIUM (USD) _____

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YYYY) _____ HEIGHT _____ M FT WEIGHT _____ KG LB GENDER M F

3. FIRST AND LAST NAME(S) _____ PREMIUM (USD) _____

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YYYY) _____ HEIGHT _____ M FT WEIGHT _____ KG LB GENDER M F

4. FIRST AND LAST NAME(S) _____ PREMIUM (USD) _____

RELATION TO APPLICANT _____ DATE OF BIRTH (MM/DD/YYYY) _____ HEIGHT _____ M FT WEIGHT _____ KG LB GENDER M F

APPLICANT (SELF) **PREMIUM** (USD) _____

DEPENDENTS PREMIUM (USD) _____

ADDITIONAL COVERAGE RIDER (USD) _____

ANNUAL ADMINISTRATION FEE (USD) 75

TOTAL PREMIUM (USD) _____

INFORMATION REGARDING ANY OTHER MEDICAL COVERAGE

Y N a) Indicate if you or any of your dependents have any other type of international health insurance.
If YES, please attach a copy of the plan's certificate of coverage and last payment receipt.

Y N b) Do you intend to continue being insured with the other company?

Y N c) Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates?
If YES, please enclose complete information.

Y N d) Have you ever been insured by Best Doctors Insurance Limited or any one of its affiliates?
If YES, indicate date (MM/DD/YYYY) _____
If this is a change of plan/deductible, please indicate previous policy number _____

FAMILY MEDICAL HISTORY

Y N Do you or any of your dependents have family history of diabetes, high blood pressure, heart disorders, cancer or congenital or hereditary disorders? **If you answered 'Yes'**, please explain:

APPLICANT _____ RELATIONSHIP WITH APPLICANT _____ DISORDER OR MEDICAL CONDITION _____

APPLICANT _____ RELATIONSHIP WITH APPLICANT _____ DISORDER OR MEDICAL CONDITION _____

APPLICANT _____ RELATIONSHIP WITH APPLICANT _____ DISORDER OR MEDICAL CONDITION _____

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HABITS

Y N Have you or any of your dependents ever smoked cigarettes, consumed products from nicotine, alcohol or illegal drugs? **If you answered 'Yes'**, please explain.

APPLICANT	TYPE AND AMOUNT	☐ Previous ☐ Actual COMSUMPTION	PERIOD (FROM-TO)

PRIMARY PHYSICIAN AND ROUTINE TEST

Y N Do you or any of your dependents have a primary care physician or consulted with a specialist? **If you answered 'Yes',** please provide the following information:

APPLICANT	NAME OF PHYSICIAN AND SPECIALTY	PHONE

Y N Any applicant has had a pediatric, gynecological or a routine examination in the last 5 years? **If you answered 'Yes',** Please provide the following information:

APPLICANT	DESCRIPTION (INCLUDING DATES AND RESULTS)

MEDICAL QUESTIONNAIRE

Answer Y Yes o N No to all questions below

SECTION A: To the best of your knowledge, have any of the persons listed on this application has or had any of the following conditions during the last ten 10 years **(with the exception of questions (a) and (b), which must be declared for lifetime)**?:

Y N a) Cancer, malignant tumors or benign tumors. **If YES**, indicate type _____

Y N b) Any medical condition that it has required surgery or any surgical procedure? **If YES**, indicate Diagnosis _____

_____ Date _____

Y N c) Kidney stones, kidney or bladder problems, urinary frequency or burning

Y N d) Goiter, thyroid problems or diabetes

Y N e) Epilepsy, paralysis, mental or nervous diseases, alcoholism, migraines

Y N f) Drug addiction for which the individual has been treated or hospitalized

Y N g) Gall bladder problems, hernia, stomach or intestinal problems, ulcers, hemorrhoids, liver problems

Y N h) Cataracts or other eye problems, ear problems

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MEDICAL QUESTIONNAIRE (CONTINUED)

Y N i) Tuberculosis, pulmonary diseases, asthma or bronchitis, sinusitis, chronic cough and throat problems

Y N j) Arthritis, rheumatism, joint disorders, spine problems, gout

Y N k) Heart disease, blood pressure problems, anemia, rheumatic fever, bleeding/clotting disorders of the blood, hemophilia,phlebitis, thrombosis, chest pain, angina, aneurysm

Y N l) Female: Menstrual alterations or menstrual hemorrhage, disorders of the reproductive organ, sexually transmitted diseases, breast disorders

Y N m) Female: Presently pregnant. **If YES**, indicate date of delivery (MM/DD/YYYY) _____

Y N n) Female: Indicate number of: Pregnancies: _____ Normal Childbirth:_____ Caesarean: _____ Abortions: _____ Reason for Caesarean: _____

Y N o) Female: Complications of pregnancy or childbirth, twin pregnancy or a child with any birth defect, congenital disease or hereditary condition

Y N p) Male: Prostate problems, sexually transmitted diseases

Y N q) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)

Y N r) Dermatitis or skin diseases, or any other skin problem

Y N s) Deviated septum, sinusitis, polyps, or other disorders of the noses

Y N t) Birth defects and congenital abnormalities, developmental delay, Down syndrome, heart/lung/kidney malformation

Y N u) Is any applicant a candidate for or recipient of, an organ, bone marrow or stem cell transplant?

Y N v) Is any applicant a candidate for or recipient of, bone/joint pin, screw, nail, wire, plate, prosthesis and/or artifical device?

SECTION B: Besides the health problems mentioned in Section A, to the best of your knowledge and understanding is there any person listed on this application who during the last five (5) years:

Y N a) Has consulted a doctor or other provider for surgical or medical treatment or for advice regarding another illness not mentioned in Section A?

Y N b) Had any health problem or symptom not mentioned in Section A or on Question (a) of this section, for which he/she has or has not consulted doctors?

Y N c) Have taken or takes any kind of medicine on a regular basis? **If YES**, please state:

NAME OF PATIENT

DIAGNOSIS

NAME OF MEDICINE AND DAILY DOSAGE | EXPENSE PER MONTH | LAST MEDICAL CHECK UP (MM/DD/YYYY)

NAME OF YOUR PRIMARY DOCTOR | TELEPHONE OF PRIMARY DOCTOR

ADDRESS OF PRIMARY DOCTOR

Y N d) Have any of the persons listed on this application lost or gained weight in the last 12 months? **If YES**, please state:

NAME

HOW MUCH? KG LB | WHAT CAUSED THE CHANGE IN WEIGHT?

Continued over

SECTION C: If you have answered **YES** on any part of Sections A or B please provide complete information in this section and attach the medical report (you may use an additional page if you need more space).

1. NAME OF PATIENT

DIAGNOSIS/TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

2. NAME OF PATIENT

DIAGNOSIS/TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

3. NAME OF PATIENT

DIAGNOSIS/TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

TEMPORARY EMERGENCY COVERAGE

From the time the Insurance Company receives the signed and completed Application and the total premium required for the Policy, through the Cover Start Date of the Policy, or sixty (60) days later, whichever date comes first, the Insurance Company agrees to cover all the individuals included in the Application up to a maximum benefit of twenty-five thousand dollars (USD$25,000) per Policy for medical expenses resulting from bodily Injuries caused by Accidents which occurred while the Temporary Emergency Coverage is in effect. Failure to pay within sixty (60) days will nullify the temporary emergency cover and coverage will instead begin the first or the fifteenth of the month, whichever is sooner, following receipt of such full payment.

This temporary emergency coverage is subject to and governed by the terms, conditions and exclusions stated in the Policy under which the individual was applying for coverage, if such Policy had been effective at the time of the Accident. The Deductible chosen by the Insured would apply to this benefit unless the Application is denied.

The fact that Injuries happened while the Application was being evaluated will not be a reason to decline an Application.

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ACKNOWLEDGEMENT AND AUTHORIZATION

BY SIGNING I UNDERSTAND AND AGREE AS FOLLOWS:

a) Best Doctors Insurance Limited (the Insurance Company) reserves the right to accept or reject your enrollment application. The coverage provided will not become effective until the Insurance Company has received full premium payment, completed underwriting, approved the application and issued the policy. The coverage will become effective on the first or fifteenth day of the month following the date on which the Insurance Company approves the application.

b) The statements and answers provided are true, complete accurate, not misleading according to my best knowledge and understanding (Full Information) correctly recorded and reviewed by me in good faith. I understand that the information supplied in this form will be decisive for the approval of my application and that any misrepresentation and/or mistake in such information will be reason for cancellation/termination of the coverage for which I am applying. The Insurance Company in its sole discretion, without an obligation of reasonableness, may terminate and/or annul the policy issued to you without prior notice. In the event of a termination the Insurance Company shall have no obligations of any nature to pay or reimburse any claims originally submitted or due to be submitted pursuant to the policy, subject to a reimbursement by the Insurance Company of any remainder of the policy premium due as calculated pursuant to the early termination provisions of the policy less any amount of benefits paid under the policy prior to this termination for false.

c) You shall be obligated to refund to the Insurance Company any moneys you received from the Insurance Company for benefits if your policy is terminated or annulled due to failure to provide Full Information and your reimbursement as described in (b) above is not sufficient for the Insurance Company to collect the amounts due.

d) I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, government agency, MIB, Inc. ("MIB") or other organization, institution or person that has any records or knowledge of me or my health or any of my dependents named in this application, to give to the Insurance Company, its reinsurers and affiliates any such information, including copies of records concerning counsel, care or treatment provided to me and/or my dependent(s) without limitation to information concerning mental illness or use of drugs or alcohol. I further authorize Best Doctors Insurance Company, its affiliates, its reinsurances to use and or disclose such information to affiliates, Providers, payors, other insurers, Third Party Administrators, vendors, consultants and any entity when necessary for our care or treatment, payment for services, the operation of our health plan or to conduct related activities and to make a brief report of our personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

e) My covered dependents and I specifically understand and agree that each has elected to allow the agent of record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates or sub-contractors.

f) The Main Applicant understands he/she is applying for an international health insurance plan that does not follow regulations and or mandatory coverage required by the authorities of his/her country of residence or other jurisdictions.

SIGNATURE OF MAIN APPLICANT

DATE (MM/DD/YYYY)

IMPORTANT:
AS AGENT, I ACCEPT FULL RESPONSIBILITY FOR THE SUBMISSION OF THIS APPLICATION AND SENDING ALL THE COLLECTED PREMIUMS. I DO NOT KNOW OF ANY CONDITION THAT HAS NOT BEEN DISCLOSED IN THIS APPLICATION WHICH COULD AFFECT THE INSURABILITY OF THE PROPOSED INSUREDS.

AGENT NAME AND CODE

AGENT SIGNATURE

DATE (MM/DD/YYYY)

PAYMENT INFORMATION

PAYMENT MODE:

- ☐ Annual
- ☐ Semi-Annual

PAYMENT METHOD:

- ☐ **Credit Card**
- ☐ **Check:** Make payable to Best Doctors Insurance Limited
- ☐ **Wire Transfer**

PAYMENT SUMMARY:

PREMIUM (USD)

ADDITIONAL COVERAGE RIDER (USD)

75

ANNUAL ADMINISTRATION FEE (USD)

TOTAL (USD)

BDIL_LATAM_GEN_AF_ENG_MAR 16

Best Doctors® INSURANCE

The insurance policy is issued by Best Doctors Insurance Limited, a Bermuda company. Insurance administration services provided by Best Doctors Insurance Holdings, LLC. on behalf of Best Doctors Insurance Limited.
www.bestdoctorsinsurance.com

Call USA Collect	1 305 269 2521
USA Toll Free Number	58 212 771 9274
Toll Free Number from Trinidad	1 888 826 9630
Fax	1 800 476 1160