# MERIDIAN CLEAR APPLICATION

*Going Your Way*

Azimuth SM
RISK SOLUTIONS

# THE MERIDIAN CLEAR APPLICATION

The Meridian Clear Insurance Plan℠ is a surplus lines product underwritten by Certain Underwriters at Lloyd's of London. It is distributed, managed and administered, as agent for and on behalf of Underwriters, by Azimuth Risk Solutions, LLC℠ (Azimuth).

## Important Information

The Meridian Clear offers two options: worldwide coverage or worldwide coverage excluding the U.S. and Canada. Both options provide coverage 24 hours a day, 7 days a week allowing you to have the freedom to choose any doctor or hospital for treatment. Please note the risks and subjects of insurance under this plan are not intended or considered by Underwriters or Azimuth to be resident located, or to be performed in any particular State of the United States, and special eligibility requirements apply. Also, this insurance is not subject to certain portability, access, renewal or other requirements of the Health Insurance Portability and Accountability Act of 1996. Please read and review all of the eligibility requirements, coverage conditions, and pre-existing condition exclusions carefully before purchasing coverage. Marketing Brochures and Evidence of Insurance containing complete terms of coverage are available upon request. Please contact Azimuth or your independent insurance agent/broker for additional details.

## Directions for Completing the Application

Failure to provide legible and complete information may delay processing of your Application.

1. In Section 1, print or type your name and the names of all other family members applying for coverage as you want them to appear on your identification card(s). Also, the mail forwarding address provided on your application will be the address where all correspondence will mailed, such as fulfillment kit, renewal forms, and any claims information. You may also elect to receive your insurance documents by email by checking the box "I would like to receive my insurance documents electronically".

## How Do I Apply?

It is easy, simply fax this completed application to 888-201-8851 or 317-423-9620 if paying by credit card.

If paying by check, we recomend first faxing the application to the number above then mailing the completed application and and payment to:

Azimuth Risk Solutions, LLC
55 Monument Circle, #1128
Indianapolis, IN 46204
USA

2. All Applications must be fully completed, signed and dated to be considered. If any questions are answered "YES" in Section 2, you must identify the family member(s) to whom the "Yes" answer applies, and include the name, address and telephone number of the attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. (Please use the space provided in Section 3, entitled "Medical Information/Prior Insurance," to provide this information). Please attach additional pages as necessary.

3. U.S. Citizens: If you or any family member applying for coverage is located in the U.S. on the date of this application, the effective date of this insurance, if issued, will be the later of:

(i) The effective date requested on the application; or (ii) The date the insured person departs the U.S.; or (iii) The date the application is accepted by Azimuth and an Evidence of Insurance issued.

4. Non-U.S. Citizens: If you or any family member applying for coverage is located in the U.S. on the date of this application and do not plan to depart the U.S., an affidavit of eligibility must be completed. Your insurance agent/broker can assist you in this regard. A new affidavit of eligibility will be required at each renewal.

5. Annual premiums may be paid by check, money order, wire transfer, or by Visa, Master Card, American Express, and Discover credit cards. Azimuth will not accept checks, money orders or wire transfers for semi-annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre- authorization to debit your credit card on the due date(s) of your future premium installment(s), and result in total payments of 110%, 112%, and 120%, respectively, of the annual premium. An optional $25 (US) or $35 (non-US) fee may be paid in addition to the premium to have your insurance documents express mailed to you after your application has been approved.

## SECTION 1

Please complete for all Family Members applying for coverage. Failure to provide all information requested will delay the application process.

| MERIDIAN CLEAR | | | | |
|---|---|---|---|---|
| Coverage Area | Deductibles | Dental Rider | Sports Rider | Express Delivery<br>$25.00 (US)<br>$35.00 (All Others) |
| Including US/ Canada | ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ $10,000 | ❑ YES ❑ NO | ❑ YES ❑ NO | ❑ $25 ❑ $35 |
| Excluding US/ Canada | ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ $10,000 | ❑ YES ❑ NO | ❑ YES ❑ NO | ❑ $25 ❑ $35 |
| Requested Effective Date: | | | Departure Date: | |

Please print your name and all family member(s) names as you would like it to appear on your identification card. Please ONLY include the names of those family members applying for coverage under the Beacon/Axis Series Group Insurance Trust (Anguilla).

| **Name**<br>**Please print your name below** | **Sex** | **Height** | **Weight** | **Date of Birth mo/day/yr.** | **Country of Citizenship** | **Personal Identification Number**<br>**(Passport, SS# or DL#)** |
|---|---|---|---|---|---|---|
| A. Applicant (last, first, middle) | ❑ Male<br>❑ Female | | | | | |
| B. Spouse (last, first, middle) | ❑ Male<br>❑ Female | | | | | |
| C. First Child (below age 19-last, first, middle) | ❑ Male<br>❑ Female | | | | | |
| D. Second Child (below age 19-last, first, middle) | ❑ Male<br>❑ Female | | | | | |
| E. Third Child (below age 19-last, first, middle) | ❑ Male<br>❑ Female | | | | | |

| **RESIDENCE ADDRESS** | | |
|---|---|---|
| STREET ADDRESS: | | CITY, STATE, POSTAL CODE: |
| COUNTRY: | TELEPHONE: | **I would like to receive my insurance documents electronically (check the box to receive your documents by email). ❑** |
| **IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE U.S. AT LEAST 6 OF THE NEXT 12 MONTHS? ❑ YES ❑ NO**<br>**(IF A NON-U.S. CITIZEN AND YOUR RESIDENCE ADDRESS IS THE U.S. AND YOU ANSWERED "NO" TO THE ABOVE QUESTION, OR THE RESIDENCE ADDRESS IS NOT COMPLETED, AN AFFIDAVIT OF ELIGIBILITY MUST BE COMPLETED).** | | |

| **MAIL FORWARDING ADDRESS** | |
|---|---|
| STREET ADDRESS: | CITY: |
| STATE, COUNTRY, POSTAL CODE: | TELEPHONE: |
| EMAIL: | |
| IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENLY L0CATED IN FLORIDA? ❑ YES ❑ NO | |
| **THE ABOVE QUESTION IS FOR SURPLUS LINES TAX DETERMINATION AND DOES NOT AFFECT COVERAGE** | |

## SECTION 2

| Please answer all questions for the Applicant and for each Family Member applying for coverage. For any question answered Yes, please explain in Section 3 of this Application. | IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1 | |
|---|---|---|
| 1. Are you or any other applicant currently disabled, pregnant, or unable to perform normal activities? | ❑YES ❑NO | |
| 2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery? | ❑YES ❑NO | |
| 3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder? | ❑YES ❑NO | |
| 4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant? | ❑YES ❑NO | |
| 5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past twelve (12) months, other than basal cell carcinoma or squamous cell carcinoma? | ❑YES ❑NO | |
| 6. Have you or any other applicant ever been diagnosed with or treated for Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, cerebral palsy, paralysis, , or transient cerebral ischemic attacks (as it relates to the conditions listed in this question)? | ❑YES ❑NO | |
| 7. Have you or any other applicant ever been diagnosed with or treated for muscular or skeletal system disorders (including but not limited to: scoliosis, osteoporosis, disc disease, vertebrae or back disease or disorders, rheumatism, fibromyalgia, rheumatoid arthritis, gout, or chronic tendonitis )? | ❑YES ❑NO | |
| **If any individual answered YES to any of the above questions, he or she does not qualify for this insurance. Thank you for your interest. If you've answered No to all the above questions, Please continue with the questions below.** | | |
| **Please answer all questions for the Applicant and for each Family Member applying for coverage. For any question answered Yes, please explain in Section 3 of this Application.** | **IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1** | |
| 8. Have you or any other applicant ever been diagnosed with or treated for heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure,heart attack, angina, arteriosclerosis, atherosclerosis, thrombosis, phlebitis, rheumatic fever or chest pain (as it relates to the conditions listed in this question)? | ❑YES ❑NO | |
| 9. Have you or any other applicant been diagnosed with or treated for diabetes or sugar in the blood or urine in the past 10 years? | ❑YES ❑NO | |
| 10. Have you or any other applicant been diagnosed with or treated for epilepsy, convulsions, seizure, stroke, migraines and/or chronic headaches? | ❑YES ❑NO | |
| 11. Have you or any other applicant been diagnosed with or treated for carpal tunnel syndrome and any advanced disease or disorder of the tendons, cartilage, bone or joints? | ❑YES ❑NO | |
| 12. Have you or any other applicant been diagnosed with or treated for thyroid, breast or other glands in the past 10 years? | ❑YES ❑NO | |
| 13. Have you or any other applicant been diagnosed with or treated for elevated blood pressure, hypertension, hypotension, heart murmur, or swelling of the feet/ankles in the past 10 years? | ❑YES ❑NO | |
| 14. Have you or any other applicant consulted a mental health professional or received inpatient or outpatient mental health advice or treatment during the last five (5) years for any mental health condition? | ❑YES ❑NO | |
| 15. Have you or any other applicant experienced a weight change of 20 pounds or more in the last twelve (12) months? | ❑YES ❑NO | |
| 16. Have you or any other applicant used tobacco of any form in the last twelve (12) months? | ❑YES ❑NO | |
| 17. Have you or any other applicant had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any drug or alcohol arrest in the past five (5) years? | ❑YES ❑NO | |
| 18. Have you or any other applicant been diagnosed with or treated for any other disease, medical problem, illness, injury or condition of any kind not listed above? | ❑YES ❑NO | |
| **If any individual answered YES to any of the above questions, he or she may not qualify for this insurance. Please note, coverage may be offered with a Medical Rider or Conditional Rate Up for coverage. All questions answered Yes, must be explained in detail in Section 3 of this Application.** | | |

## SECTION 3

Medical Information

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. **Please attach additional pages as necessary.** Azimuth reserves the right to request additional medical information prior to acceptance of this Application.

| Family Member (use letters from Section 1) | Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s) | Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone Number | Date(s) of Treatment/Service |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

MEDICAL RELEASE: I (we) hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis for any physical or mental condition, or financial and employment status, to provide such information to Azimuth Risk Solutions, LLC. and/or Underwriters and my agent/broker involved in procurement of this application.

ACKNOWLEDGEMENT: I (we) understand and agree that: (i) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this Application is acting solely as my legal agent or representative and is representing my (our) personal interest, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of Azimuth or Underwriters, (ii) marketing brochures and Evidence(s) of Insurance wordings are available to us prior to application upon request, (iii) any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the three (3) years prior to the effective date of coverage and time of this insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date herein (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance for a period(s) up to twelve (12), twenty-four (24), or the duration of this insurance, and thereafter, certain benefits and/or all benefits will be reduced as stated in the Evidence of Insurance (available upon request prior to application), and/or the Schedule of Benefits as shown on the brochure and application, (iv) the subjects of insurance applied for are not intended or considered by the applicant(s), Azimuth or Underwriters to be resident, located, or to be performed in any particular state of the United States, and (v) Underwriters, as carrier and Underwriters of the plan, is solely liable for the coverage's and benefits to be provided under this insurance, Azimuth acts solely as a agent/representative for Underwriters and has no independent liability under the Master Policy or any Evidence(s) of Insurance issued by the Master Policy.

CERTIFICATION: I (we) hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I (we) have read the questions contained in this Application or that the questions have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions and other information disclosed herein, I (we) have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

SATISFACTION GUARANTY/REVIEW PERIOD: It is understood I (we) will have 7 days from the effective date to review the Evidence of Insurance and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

SUBSCRIPTION: I (we) hereby apply for membership in the Beacon/ Axis Series Group Insurance Trust (Anguilla), and for the insurance provided to Participating Member(s) by certain Underwriters at Lloyd's. I (we) understand and agree that (i) no coverage will be effective until this Application has been duly accepted in writing by Azimuth Risk Solutions, LLC. (Azimuth), (ii) no modifications or waiver relating to this Application or the coverage applied for will be binding upon Azimuth or Underwriters unless approved in writing by an officer of Azimuth or Underwriters, (iii) Azimuth and Underwriters rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void this insurance, and any and all claims and benefits there under will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with Azimuth Risk Solutions, LLC. a Indiana based company, and registered agent/representative of Certain Underwriters at Lloyd's, London, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Evidence of Insurance shall be deemed issued and made in Indianapolis, Indiana, I (we) understand that Certain Underwriters at Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I (we) understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

_____ _____

Signature of Applicant, Guardian or Proxy Date (Mo./Day/Yr.)

_____ _____

Signature of Spouse Date (Mo./Day/Yr.)

## SECTION 4

Premium Calculation (Please note, Applications without payment of premium will not be approved)

**Annual premiums may be paid by check, money order, wire-transfer, or by Visa, MasterCard, American Express, and Discover card. Azimuth will not accept checks, money orders, or wire-transfer for semi-annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date (s) of your future premium installment(s) prior to the expiration date. Additional fee(s) may be charged to your credit card if authorized for express delivery of your insurance documents upon request; such fee(s) would be in addition to insurance premium.**

| | (1) MEDICAL PREMIUM | (2) OPTIONAL DENTAL RIDER | (3) OPTIONAL SPORTS RIDER | (4) TOTAL |
|---|---|---|---|---|
| **A. Applicant** | $ | $425.00 ❑ | $250.00 ❑ | $ |
| **B. Spouse** | $ | $425.00 ❑ | $250.00 ❑ | $ |
| **C. First Child** | $ | $285.00 ❑ | $250.00 ❑ | $ |
| **D. Second Child** | $ | $285.00 ❑ | $250.00 ❑ | $ |
| **E. Third Child** | $ | $285.00 ❑ | $250.00 ❑ | $ |
| | | | **Please add all totals listed in column number 4 and list total here →** | $ _____ **(Subtotal A)** |

First Payment Total Due

***Modal factors:** ❑ **Annual = 1.00** ❑ **Semi-annual = 0.55** ❑ **Quarterly = 0.28** ❑ **Monthly = .20**

**(Please select a payment mode)**

$_____ **X** _____ = $_____ + Optional express mailing fee ($25 in US, $35 outside US): $_____
**(Subtotal A)** ***Modal Factor** **Total**

**Total First Payment Due:** $_____

Future Installment Payment s Due (For semi-annual, quarterly, or monthly payment modes)

***Modal factors:** ❑ **Semi-annual = 0.55** ❑ **Quarterly = 0.28** ❑ **Monthly = .10**

**(Please select a payment mode)**

$_____ **X** _____ = $_____
**(Subtotal A)** ***Modal Factor** **Total Premium due for all remaining payments**

**Please provide a valid email address in Section 1. All future correspondence regarding monthly, quarterly and semi-annual payments will be made via email to the address provided above in Section 1. If you elect the monthly payment mode, we will draw your first two months during your initial payment, leaving 10 additional monthly payments. During your last month of coverage there will be no payment due.**

## SECTION 5

Method of Payment

❑ Check (annual only) ❑ Money Order (annual only) ❑ Visa Card ❑ Master Card ❑ American Express Card ❑ Discover Card

All payments must be made in U.S. dollars. Please make checks and money orders payable to Azimuth Risk Solutions, LLC. (Azimuth). If paying by credit card, I (we) authorize Azimuth to debit my Visa card, MasterCard, American Express card, or Discover card account for the total amount due. If I have selected monthly, quarterly, or semi-annual payment modes, I (we) hereby request and authorize Azimuth to debit my credit card account for the proper installment payment due on the due date set forth by Azimuth. This authorization will remain in effect for up to 12 months or as long as I (we) continue to renew my (our) coverage, or until coverage is revoked in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that coverage will not be effective if the credit card company denies the charge. Note: On American Express cards, the CSC is a 4 digit number printed on the front above the account number. On all other cards, it is a 3 digit value printed on the signature panel on the back of the card immediately following the account number, or a portion of the account number.

| **Name as it appears on card:** | | **Billing Address:** |
|---|---|---|
| **Credit Card Number:** | **Expiration Date:** | **Card Security Code (CSC):** |
| **Daytime Phone Number:** | **Authorized Signature:** | |

I (we) hereby apply for membership in the Beacon/Axis Series Group Insurance Trust (Anguilla) and for the insurance provided to Participating Members by Lloyd's, London. I (we) have personally completed this Application. I (we) represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I (we) understand Azimuth Risk Solutions, LLC. relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I (we) understand that any misrepresentation or omission contained herein will void my (our) insurance and all claims will be forfeited. I understand that this insurance contains Pre-existing condition exclusions, Pre-certification penalties, and other restrictions, exclusions and limitations set forth in the Policy. I understand that I may request a complete copy of the Master Policy at any time and that Azimuth Risk Solution agrees to provide it to me. I understand that if this Application is not accepted, the sole obligation of Azimuth Risk Solutions is to return to me any premium(s) paid. I (we) understand that Certain Underwriters at Lloyd's, London as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I (we) understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I (we) understand that the insurance Agent or Broker, if any, assisting me (us) with this Application is a representative of me (us) the Applicant. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition of any Family Member listed on this Application to release said information to Azimuth Risk Solutions, LLC.

_____ _____

Signature of Applicant, Guardian or Proxy — Date (Mo./Day/Yr.)

_____ _____

Signature of Spouse — Date (Mo./Day/Yr.)

## SECTION 6

Insurance Agent/Broker Use Only

| **Azimuth Agent Number:** 559cb0ae | | **Azimuth Agent Name:** Ramesh Patel |
|---|---|---|
| **Company Name:** Community Insurance Agency, Inc. | | |
| **Company Address:** 425 Huehl Rd, Suite# 22-A | | **City, State, Postal Code:** Northbrook, IL 60062 |
| **Phone:** 1-800-344-9540 or 1-847-897-5120 | **Fax:** 1-847-897-5130 | **Country:** United States |
| **Website:** www.TravelHealthQuote.com | | **Email:** ramesh@ciainsagency.com |
| **Agent/Broker Signature:** | | |

PRODUCTS MARKETING BY:

COMMUNITY INSURANCE AGENCY INC

QUALITY SERVICE TO THE COMMUNITY SINCE 1980

**Celebrating 30 years in Insurance Business!**

425 Huehl Rd, Suite# 22-A
Northbrook, IL 60062

Toll Free: 1-800-344-9540
Ph: 1-847-897-5120
Fax: 1-847-897-5130

E-mail: Info@ciainsagency.com
Website: www.TravelHealthQuote.com