Signature Healthcare Application

Please submit this form and all related correspondence to:

Service Address:
1901 Ponce De Leon Blvd.
Coral Gables, FL 33134 USA

Customer Service: + 1 305.405.8929
Toll Free: + 1 800.222.3002
Fax: + 1 305.443.9671

app-info@weadirect.com
www.weadirect.com

WEA Medical Insurance products are underwritten by Premier Assurance Group SPC Ltd. (the Company) under its Global Assurance Segregated Portfolio and administered for and on behalf of the Company, by Lyncpay LLC.

A. INSTRUCTIONS

1. Please read all agreement terms carefully and complete all sections of the application. If space provided is insufficient, please attach additional sheet(s) of paper to the application.
2. If you are signing on behalf of the applicant, please provide power of attorney documents with the application.
3. Enter the names of immediate family members applying for coverage.
4. Enclose first payment with the application.
5. All payments should be made payable to: Lyncpay, LLC
   Lyncpay is WEA's affiliate Third Party Administrator (TPA)

Before you begin, please select the option you are applying for:

☐ **New Policy** ☐ **New Enrollment** ☐ **Reinstatement** ☐ **Change of Plan, Deductible or Area of Coverage**

B. PERSONAL INFORMATION

Applicant's Name (Last, First, MI)

Nationality

Gender ☐ M ☐ F

Passport or Federal ID #

Date of Birth MM/DD/YYYY

Host Country

Occupation

Annual Income (in USD)

Mailing Address: *This address will be used to send all policy documents.*

Address (Street and Number)

City

State

Country

Postal Code

Home Phone Number

Email Address

WEA, LTD. USE ONLY

Date Processed DD/MM/YYYY

Date Received DD/MM/YYYY

Effective Date DD/MM/YYYY

Final Year Rates

Administrator Signature

C. INSURED INFORMATION

Please complete all information below for you and each family member applying for coverage.

	Full Name	Relationship	Marital Status	Nationality	ID Number	Sex M/F	Date of Birth	Full Time Student (Y/N)	Height	ft/in / m	Weight	lb / kg
A)							MM/DD/YYYY					
B)							MM/DD/YYYY					
C)							MM/DD/YYYY					
D)							MM/DD/YYYY					
E)							MM/DD/YYYY					
F)							MM/DD/YYYY					
G)							MM/DD/YYYY					
H)							MM/DD/YYYY					
I)							MM/DD/YYYY					
J)							MM/DD/YYYY					
K)							MM/DD/YYYY					
L)							MM/DD/YYYY					
M)							MM/DD/YYYY					
N)							MM/DD/YYYY					
O)							MM/DD/YYYY					
P)							MM/DD/YYYY					
Q)							MM/DD/YYYY					
R)							MM/DD/YYYY					
S)							MM/DD/YYYY					

D. OTHER HEALTH CARE COVERAGE

1. Do you (or any family member listed on this application) have other medical insurance coverage? ☐ Yes ☐ No

If **Yes**, please provide the name of the other medical insurance company

Effective Date: MM/DD/YYYY

Expiration Date: MM/DD/YYYY

Who is insured? (Check all that apply)
Please provide copy of Certificate of Coverage for all that apply.

☐ Yourself ☐ Spouse ☐ Dependent Children

Policy Number

Insurance Company Phone Number

2. Are you applying for the WEA Plan in order to replace another sickness and accident or other health policy that you presently have in effect? If **Yes**, please provide copy of your Certificate of Coverage from your previous insurance company. ☐ Yes ☐ No

3. If not currently covered by another health policy, when was the last date that the insured/dependents were covered by a private/corporate or government medical plan? MM/DD/YYYY

4. Has any other insurance company declined the application or renewal or has modified, or given a rate-increase to a life or health policy for you or any of your dependents? ☐ Yes ☐ No

If yes, who and why?

E. HEALTH RELATED INFORMATION

Please indicate **Yes** or **No**, in the corresponding box if the proposed applicant(s) (including any family members applying for coverage) have ever been diagnosed with, had symptoms of, had medical testing or been treated for any:

*If **Yes**, please indicate the affected applicant(s) by placing the corresponding letter from Section C: Insured Information (the letter is located on the left hand side of each dependent(s) name), in the shaded box to the right. Please provide an explanation on the affirmative answers in the following section.*

	Yes	No	Applicant(s)
1. Allergies	☐	☐	
2. Seizures, epilepsy, stroke, headaches, trigeminal neuralgia, vertigo, neuropathy, myasthenia gravis, amyotrophic Lateral Sclerosis, multiple sclerosis, Parkinson, paralysis or head trauma, or other neurological condition?	☐	☐	
3. Cataract, glaucoma, or any eye disorder, any ear disorder, sinusitis, nasal trauma or other disorder of the nose or vocal cords?	☐	☐	
4. Abuse or dependency of alcohol, drugs or of other harmful substance?	☐	☐	
5. Heart failure, heart attack, angina, chest pain, arteriosclerosis, elevated blood pressure, swelling of feet/ankles, heart murmur, rheumatic fever, heart valve disease, arterial or venous insufficiency, thrombosis, aneurysm, varicose veins, elevated cholesterol or triglycerides congenital defect or other disorder of the heart or blood vessels?	☐	☐	
6. Asthma, bronchitis, emphysema, pulmonary fibrosis, pulmonary nodule, pleural effusion, bronchiectasis, sarcoidosis, pulmonary embolus, sleep apnea, tuberculosis, or other disorder of the respiratory system?	☐	☐	
7. Cancer, pre-cancerous condition, tumor, cyst, or mass?	☐	☐	
8. High or low glucose in blood, diabetes, diabetes insipidus, hyperthyroidism, hypothyroidism, thyroid nodules, high or low levels of calcium, Addison's disease, or pheochromocytoma?	☐	☐	
9. Blood or pus in the urine, kidney stones, renal insufficiency, nephrotic or nephritic syndrome?	☐	☐	
10. Gastro esophageal reflux (GERD), achalasia, esophageal strictures, Zenker's diverticulum, esophagitis, barret esophagus, peptic ulcer, gastritis, Helicobacter pylori infection, gallbladder or bowel disorder, Crohn's disease, colitis, diarrhea, pancreatitis, diverticulosis, hemorrhoids, hernia, cirrhosis, gastric bypass or other weight reduction surgery, or any other disorder of the digestive system?	☐	☐	
11. Acquired Immune Deficiency Syndrome (AIDS) or been tested positive for Human Immunodeficiency Virus (HIV) or for any other Immune System Disorder?	☐	☐	
12. Prostate enlargement, elevated Prostate-specific Antigen (PSA), abnormal vaginal bleeding, fibroids, nodules cysts or other disorders of the breasts, fallopian tubes, ovaries, uterus diseases, vagina, prostate, penis, or testis, or other disorder of the reproductive system?	☐	☐	
13. Osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, osteomyelitis, lupus, gout, osteoporosis, spinal stenosis, herniated disc, carpal tunnel syndrome, or other disorders of the joints, bones, muscles or vertebral column?	☐	☐	
14. Acne, actinic keratosis, melanoma, squamous cell or basal cell carcinoma, psoriasis, eczema or any other skin disorder?	☐	☐	
15. Mental disorder, depression, anxiety, dementia, schizophrenia or other mental or behavioral disorder?	☐	☐	
16. Anemia, Leukemia, lymphoma, or any disorder of the blood or lymph nodes?	☐	☐	

E. HEALTH RELATED INFORMATION (Continued)

Please indicate **Yes** or **No**, in the corresponding box if the proposed applicant(s) (including any family members applying for coverage) have ever been diagnosed with, had symptoms of, had medical testing or been treated for any:

*If **Yes**, please indicate the affected applicant(s) by placing the corresponding letter from Section C: Insured Information (the letter is located on the left hand side of each dependent(s) name), in the shaded box to the right. Please provide an explanation on the affirmative answers in the following section.*

	Yes	No	Applicant(s)
17. Congenital or hereditary diseases or any other type of physical disorder, deformity or ailment?	☐	☐	
18. Is any applicant currently taking any prescribed medication, is under medical treatment or has been advised of the possibility or need to undergo treatment now or in the future?	☐	☐	
19. Has any applicant had a surgery or been recommended to undergo a surgery that is still pending?	☐	☐	
20. Is any applicant currently pregnant?	☐	☐	
21. Any sickness, injury, accident or physical impairment not mentioned above?	☐	☐	
22. Had a weight change of 10 pounds or more during the last year?	☐	☐	
23. Has any applicant had a medical consultation, hospital confinement, treatment, medical exam or any other health related issue that was not mentioned before?	☐	☐	

Dental Questions:
Not required for CARE & SELECT options. Must be completed when ELITE option is chosen.
*Please provide details in Section G: General Notes to all dental questions answered **Yes**.*

	Yes	No	Applicant(s)
24. Any fillings needed? If **Yes**, how many? _____	☐	☐	
25. Any crowns needed?	☐	☐	
26. Any denture/bridge work needed?	☐	☐	
27. Missing teeth needing replacement?	☐	☐	
28. Periapical disease (i.e., root canal) needing treatment?	☐	☐	
29. Have all individual(s) had a dental exam within the last 12 months? If **No**, give details. _____	☐	☐	
30. Any teeth need extraction?	☐	☐	
31. Periodontal disease needing treatment?	☐	☐	
32. Any orthodontic treatment needed?	☐	☐	
33. Any surgery needed?	☐	☐	
34. Other? Please specify. _____	☐	☐	

Additional Question:

Please indicate **Yes** or **No**, in the corresponding box.

	Yes	No	Applicant(s)
35. Do you or any other applicant participate in professional sports?	☐	☐	

E. HEALTH RELATED INFORMATION (Continued)

If you answered **Yes** to any of the health related questions, please provide the information needed. Place the number to the question your corresponding answer is referring to in the 'Number' box below. If you need more space for additional information, please use the General Notes section on the bottom of page 7, include any supporting documents separately by attaching them to the back of this application.

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

Number Name of Insured | Diagnosis | Current Condition

Treatment | From MM/DD/YYYY | To MM/DD/YYYY | Physician Name | Phone

E. HEALTH RELATED INFORMATION (Continued)

If you answered **Yes** to any of the health related questions, please provide the information needed. Place the number to the question your corresponding answer is referring to in the 'Number' box below. If you need more space for additional information, please use the General Notes section on the bottom of page 7, include any supporting documents separately by attaching them to the back of this application.

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

Number Name of Insured Diagnosis Current Condition

Treatment From MM/DD/YYYY To MM/DD/YYYY Physician Name Phone

F. FAMILY MEDICAL HISTORY

1. Please check here if any of the following applicant(s) do not have siblings: ☐ Primary Applicant ☐ Spouse

2. Have you or any other applicants' parents, brothers or sisters suffered from Insanity, Cancer, Epilepsy, Diabetes, Stroke, High Blood Pressure, Kidney or Heart Disease, Paralysis or any hereditary/familial disorder such as Huntington's Chorea? ☐ Yes ☐ No

If **Yes**, please provide details, including the name and relationship of the affected relative.

3. Has any near relative or any person in any home which you have lived suffered from Tuberculosis? If **Yes**, please give date of last contact. ☐ Yes ☐ No

G. GENERAL NOTES

Please use this section to provide additional information related to this application.

H. COVERAGE SELECTION INFORMATION

Requested Effective Date

MM/DD/YYYY

The Requested Effective Date must be the 1st or the 15th of the month. The Requested Effective Date must also be within 30 days of submitting your application and cannot be before your date of departure from the United States or your country of residence.

Choose your plan ☐ **CARE** ☐ **SELECT** ☐ **ELITE**

Choose your deductible ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Area of Coverage ☐ Worldwide ☐ Worldwide excluding the U.S.

Optional Maternity Rider ($3,250 additional fee):
Available for CARE & SELECT plan options only. ELITE option includes maternity benefits. ☐ Yes ☐ No

Optional Life Insurance:
All plans offer Life, and Accidental Death and Dismemberment (AD&D) coverage on the primary insured only.
Please select from the following face amounts:

Coverage Amount ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

Optional Travel Assistance Rider (Includes coverage up to $10,000 per event):

☐ No ☐ Yes

Please select one of the following. I would like Travel Assistance Coverage for:

☐ Primary policyholder only ($150 annual fee) ☐ Primary policyholder and all dependents ($300 annual fee)

You may add up to two primary beneficiaries, however, the percent allocated combined must equal 100%.
If for any reason, one of the primary beneficiaries is no longer alive, their allocation will be distributed to the Contingent beneficiary.

		Percentage Allocation for Each Beneficiary
Primary Beneficiary 1	Relationship	%
Primary Beneficiary 2	Relationship	%
Contingent Beneficiary	Relationship	

I. RENEWAL CONTACT INFORMATION

Please specify the best way to contact you at the time for renewal of your plan:

☐ Mail (please provide mailing address)

☐ Fax (please provide fax number)

☐ Email (please provide email address)

J. PREMIUM PAYMENT OPTIONS

A check payable to **Lyncpay** for the total premium due (calculated below) or a credit card authorization must be included with this application. The application will not be processed without the premium deposit. All deposits will be processed once the policy has been approved.

CALCULATE YOUR PREMIUM

Enter the annual premium for each applicant. When applying as a family, the first two dependent children under 10 years of age will be covered free of charge if both parents are included on the application:

Policy Holder $

Spouse $

Dependent(s)/Child(ren) $

A. Sub Total $

B. ☐ Optional Maternity Rider $3,250 (Available on CARE and SELECT options only, ELITE option includes maternity benefits)

C. Optional Term Life & AD&D

☐ $10,000 ($40 annual) ☐ $25,000 ($100 annual)
☐ $50,000 ($200 annual) ☐ $75,000 ($300 annual)
☐ $100,000 ($400 annual) ☐ None

D. Optional Travel Assistance Rider

☐ $150 for Policyholder ☐ $300 for Policyholder + dependents

E. Payment Factors

☐ Annual (x 1) ☐ Quarterly (x 0.28)
☐ Semi Annual (x 0.55) ☐ *Monthly (x 0.10)

A.	+	B. (if chosen)	+	C. (if chosen)	+	D. (if chosen)	=		+	35.00 (Policy Fee)	×	E.	=	$ Total Premium Due

*Please note if you have selected a monthly payment factor, Lyncpay must have your credit card information on file so that once your policy has been approved, monthly payments can be scheduled via our automatic recurring payment option.

K. CREDIT CARD PAYMENTS

Billing Information

Name

Street

City State Postal Code

Phone 1 Phone 2

Fax Email

Foreign Country Contact Information (REQUIRED)

Street

City State Postal Code

Phone 1 Phone 2

Fax Email

Credit Card Authorization: ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number Expiration Date (MM/YYYY) CCV Code Name as it appears on card Daytime Phone

Signature

I authorize Lyncpay to debit my Visa/ MasterCard/ American Express account for the total amount due. If I have elected installments, I authorize Lyncpay to debit my account for the proper installment amounts on the due dates of those installments. This authorization will remain in effect for up to 12 months or longer if the policy is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card Company.

L. AUTHORIZATION TO RELEASE INFORMATION

By means of this document, I authorize the company to obtain medical information from doctors, or members of the medical profession, hospitals, clinics, insurance companies, corporations, organizations, agencies or institutions or persons that have information or documents in reference to my health or that of my spouse or children, for the purpose of the completion of our review of:

A) My application for acceptance to a medical insurance plan; or
B) Claims in relation to my medical insurance plan.

A copy of this authorization will be as valid as the original.

M. JOINDER AND PARTICIPATION AGREEMENT

Certification: I (we) hereby certify, represent and warrant to WEA and the Company that: (i) I (we) have read the questions contained in this Application or they 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 condition 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 is signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and 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.

Acknowledgment: I understand that, to the extent permitted by law, false statements may result in the denial of claims or in my insurance coverage being terminated as of its elective date with no benefits payable. I understand that conditions which are disclosed on this form may be subject to all conditions of my plan including any pre-existing condition limitations, employee actively at work and dependent health condition requirements. I also acknowledge that I am applying for this insurance for my assignment and/or residency outside the United States. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Medical Release: I (we) authorize any doctor, practitioner of the healing arts, hospital, clinic, health care 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 of any physical or mental condition, and/or employment status, to provide such information to WEA and/or the Company and my producer/ broker involved in procurement of this application, insurance coverage, Explanation of Benefits (EOB), and/or Medical Claims information.

Joinder Agreement: I (we) hereby apply to the PA Global Trust for international medical insurance as offered by the company on the date of its receipt hereof. Reference is made to the Declaration of Trust dated July 23rd 2013 (the "Declaration of Trust") made by Caledonian Trust (Cayman) Limited (the "Trustee"). The undersigned, being referred to herein as the "Participant", hereby agrees to become a party to and be bound by the terms of the Declaration of Trust, including any amendments thereto, and to the establishment of the Insurance Fund created thereunder in respect of Premier Assurance Group SPC Ltd. as Settlor. This Joinder and Participation Agreement shall form a part of the Declaration of Trust. Capitalized terms not denied herein shall have the meanings ascribed to them in the Declaration of Trust. The Participant requests that the international insurance benefits indicated in the Policy be provided for the Participant and dependents (as applicable) and, subject to acceptance by the Policy Provider, agrees to be bound by the terms of the Policy issued pursuant to the provisions of the Declaration of Trust. The benefits provided shall be in accordance with the Policy and shall be subject to the terms of such Policy and to the terms of the Declaration of Trust. Coverage under the Policy will commence as of the date of approval by the Policy Provider and shall continue until withdrawal by the Participant in accordance with Clause 2 of Article VIII of the Declaration of Trust. In the event of such withdrawal, the Participant agrees to relinquish any and all claims the Participant may then or thereafter have to any portion of the Insurance Fund, except for benefits incurred, dividends and surrender values payable at the time of such withdrawal. The Participant agrees to make such Contributions as are required under the terms of the Policy and any other amount determined from time to time by the Policy Provider. The Participant agrees to furnish, and to permit the inspection of, any records or information which may be required by the Trustee or by the Policy Provider in connection with the administration of the Insurance Fund. The Participant understands that the Policy international insurance provision will be provided in accordance with the provisions of the Declaration of Trust subject to the laws of the Cayman Islands and that the Trustee is not responsible for the Participant's compliance with applicable local law.

Review Period: It is understood I (we) will have 15 days from the effective date to review the insurance Certificate and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by submitting a written request retroactive to the effective date within 15 days of the effective date and will receive a full refund of premium paid.

Important Notice Regarding Patient Protection and Affordable Care Act (PPACA): WEA is not subject to, and does not provide benefit required by, PPACA. Please note that it is solely your responsibility to determine if PPACA is applicable to you in order to avoid tax penalties that may be imposed on U.S. citizens and U.S. residents who are required to maintain PPACA compliant coverage but do not do so.

This authorization is valid for 90 days from date signed. However, I can revoke this authorization at any time by giving written notice to the company. I understand that my revocation will not affect the rights of any individual who has acted in reliance of this authorization prior to receive my notice of revocation.

Applicant or Authorized Person's Signature

Date Signed

MM/DD/YYYY

Applicant or Authorized Person's Printed Name and Relation

Spouse's or Authorized Person's Signature
(must sign when Spouse coverage is requested)

Date Signed

MM/DD/YYYY

PRODUCER USE ONLY

PRODUCER INFORMATION

Producer Code

Producer Name

Agency

Email

Address

Signature

Date Signed

MM/DD/YYYY

We are with you℠

WEA℠

www.weadirect.com

app-info@weadirect.com

A pa group Division