RESIDE® BLUE

MARITIME MEDICAL INSURANCE

Continuous Coverage On Duty & While Signed Off. Coverage For Families & Individuals.

SEVENCORNERS

PRIMARY SCHEDULE OF BENEFITS

The following is a brief summary of your benefits. Please note: a Policy Period is 364 days in length.

Lifetime Maximum Benefit	$5,000,000 per insured person.
Policy Period Deductible Options	$250; $500; $1,000; $2,500; $5,000 Maximum of 3 deductible payments for families enrolling on one application. Any eligible expenses incurred and applied to your policy period deductible in the last 30 days prior to your renewal date will carry over and be applied to the next policy period deductible.
Inside Of The United States	After the deductible, we pay 80% of the next $5,000 of eligible expenses, then 100% to the policy maximum. If treatment is received from an approved PPO service provider while you are in the U.S., we will reduce the applicable deductible by 50% & waive coinsurance. Expenses must be pre-notified using Seven Corners' pre-notification program.
Outside Of The United States	After the deductible, we pay 100% of eligible expenses to the policy maximum. Expenses must be pre-notified using Seven Corners' pre-notification program.
Inpatient Hospital Expenses	Average semi-private room and board; usual, reasonable, and customary physician charges, prescription medications, durable medical equipment, nursing services and x-rays up to the policy maximum.
Intensive Care	Intensive Care room and board; usual, reasonable, and customary physician charges, prescription medications, durable medical equipment, nursing services and x-rays up to the policy maximum.
Surgery	Usual, reasonable, and customary charges for surgery, physician and anesthetics up to the policy maximum.
Hospital Daily Indemnity Benefit	$50 per day *($1,000 maximum per policy period)* while hospitalized outside of the U.S. & Canada. This payment is not related to the hospital charges & is paid in addition to other eligible benefits. Please see the Benefit Options section of this brochure for an optional rider to increase this benefit to $200 per day.
Outpatient Treatment	Usual, reasonable, and customary charges for emergency treatment, surgery, and prescription medication up to the policy maximum.
Physiotherapy, Chiropractic	Up to $75 per visit *($10,000 Lifetime Maximum)*, when referred in advance by a physician.
Medical Supplies	Usual, reasonable, and customary charges up to the policy maximum.
Ambulance	Usual, reasonable, and customary charges up to the policy maximum.

PRIMARY SCHEDULE OF BENEFITS

Mental & Nervous	Usual, reasonable, and customary charges up to a maximum of $10,000 per policy period after a 364-day waiting period. Inpatient limited to a maximum of 45 days per policy period. Outpatient limited to a maximum of 40 visits per policy period at 70% of eligible expenses. Lifetime Maximum of $30,000.
Supplemental Accident Benefit	Up to $300 reimbursement per covered injury due to accident. This is provided before applying any deductible.
Amateur Sailboat Racing Benefit	Up to $15,000 per policy period for covered accidents or illness subject to a $60,000 lifetime maximum. An additional deductible of $1,500 applies per policy period. Also provides accidental death and dismemberment benefits (AD&D) calculated at 25% of the principal sum percentage for 24-hour AD&D, according to the Table of Losses in the certificate and limited to $25,000 Lifetime Maximum.
Dental	Usual, reasonable, and customary charges for repair and replacement of sound, natural teeth damaged as a result of an accident, limited to $500 per policy period. A Dental Benefit Rider may be purchased to expand dental coverage. Please see details included in this brochure.
Emergency Medical Evacuation	$250,000 limit per person per policy period – when adequate medical facilities and/or treatment are not available - *(Pre-approval required).*
Repatriation Of Remains	$25,000 limit per person - *(Pre-approval required).*
Emergency Medical Reunion	$10,000 limit per person per policy period – *(Pre-approval required).*
Preventive Benefits	Females and males up to $250 per policy period for checkups, routine physical exams, inoculations and vaccinations, female preventative exams and mammograms after a 180-day waiting period. Not subject to deductible or coinsurance.
Well Child Care (Under age 19)	Up to $200 per policy period for checkups and routine visits after a 180-day waiting period.
Accidental Death & Dismemberment (AD&D)	24-hour AD&D: Principal Sum: $10,000 for insured and spouse, $2,000 for dependent children. Common Carrier AD&D: Principal Sum: $40,000 for insured and spouse, $8,000 for dependent children.
Lifetime Transplant Benefit	Up to $1,000,000 per insured person.

BENEFIT OPTIONS

Seven Corners offers additional benefit options for your review and possible selection. These are in addition to the standard Reside Blue program benefits and cannot be purchased independently.

AD&D Principal Sum Rider	Reside Blue includes a standard Accidental Death & Dismemberment (AD&D) Principal Sum as mentioned above. Additional amounts are available to provide further protection should something happen to you or your family during your policy period. *For the primary insured, additional amounts of $100,000; $200,000; $300,000; $400,000 or $500,000 are available. Additional amounts may not exceed 7 times your annual income.*

BENEFIT OPTIONS (CONT.)

Dental Rider

Our optional dental plan provides limits per person as follows: $500 for Policy Period 1, $750 for Policy Period 2, $1,000 for Policy Period 3 and subsequent years. Each policy period requires a $100 deductible per person per policy period. Covered percentages are below.

Benefits	Policy Period 1	Policy Period 2	Policy Period 3 & After
Class I Preventative Benefits (90-day waiting period)	100%	100%	100%
Class II Standard Benefits (180-day waiting period)	55%	70%	85%
Class III Significant Dental Benefits (180-day waiting period)	30%	40%	50%

Class I - 2 oral exams, bitewing x-rays, & 1 topical fluoride treatment (through age 19) per policy period, 1 full mouth x-ray & 1 cleaning every 180 days, sealants for children through age 12.

Class II - Fillings (amalgam, silicate, acrylic, synthetic porcelain, composite); x-rays; extractions; treatment for root canal, periodontal & other gum disease; oral surgery (unless covered by medical plan); general anesthesia when necessary for oral surgery; emergency palliative treatment; antibiotic injections.

Class III - Initial installation of fixed bridgework, partial removable denture, full removable denture; replacement of existing removable denture or fixed bridgework, temporary full denture; add teeth to existing partial removable denture or bridgework; inlays & onlays; crowns & replacements; repair/recementing of crowns, inlays, onlays, dentures, bridgework

Sports Rider

$25,000 lifetime maximum for mountaineering up to 4500 meters where ropes or guides are normally used, hang gliding, kite surfing, whitewater rafting, snowmobiling (does not include racing), parachuting & bungee jumping and $7,500 lifetime maximum for amateur sports or interscholastic athletics sponsored by a school or organization when not engaged for wage or profit.

Hospital Daily Indemnity Rider

$150 per night *(in addition to the standard benefit of $50)* when you are hospitalized outside the U.S. and Canada. This benefit is not related to the hospital charges & is paid in addition to all other eligible benefits.

Professional Sailboat Racing Rider

This rider pays eligible benefits incurred as a result of a covered accident or Illness while participating in professional sailboat racing, to a maximum of $100,000 per policy period. You will also receive Accidental Death and Dismemberment (AD&D) benefits calculated at 25% of the principal sum percentage for 24-Hour AD&D according to the Table of Losses in the certificate, limited to $25,000 Lifetime Maximum.

Professional Sailboat Racing is defined as: The pursuit of sailboat racing for profit or gain as a hired or professional crewmember in a race sanctioned or sponsored by a recognized governing organization.

Pregnancy & Newborn Benefit Rider

Usual, reasonable, and customary charges up to $7,500 per pregnancy with newborn coverage of $25,000 for the first 31 days after birth. Must be selected at time of initial coverage purchase. May be discontinued at renewal but may not be added at a later date. Available to primary insured or spouse only. Waiting period of 364 days before the benefit begins. Requires pre-notification within the first 90 days of pregnancy.

ABOUT **RESIDE® BLUE**

WHY CHOOSE RESIDE BLUE?

Mariners require coverage that provides security, flexibility and benefits unique to the demands of today's marine industry. With coverage on-board the vessel and when signed off, you have a true universal policy, created for the mariner lifestyle. Sail and travel anywhere with the confidence that you are protected with comprehensive, marine-specific coverage providing the safety you deserve.

All members must be at least 14 days old and younger than 75 at application time.

With a worldwide network of providers, a 24-hour assistance team, and a seasoned administrative staff, we are here to ensure you receive the care you need.

HOW LONG WILL I BE COVERED?

If coverage begins before your 75th birthday, you may renew, at the discretion of the underwriter, as long as you remain eligible and pay your renewal premium. You will not be required to answer medical questions to renew, and you cannot be singled out for cancellation.

WHO CAN PURCHASE RESIDE BLUE?

You must currently or usually be an employee aboard a sea-going vessel or consider a sea-going vessel as your primary residence. You must also not be eligible and/or able to secure adequate U.S. domestic health insurance providing continuous coverage worldwide. Finally, you must complete the Declaration of Residence or provide a non-U.S. residence address.

WORLDWIDE COVERAGE

You may choose from two coverage areas, each with different pricing. With both options, your time in the U.S. must be limited to 180 days during any given 364-day period.

If you are residing in or traveling to the U.S. or Canada, you may choose Geographical Treatment Area A *(worldwide coverage including the U.S. and Canada)*.

If you will not spend time in the U.S. or Canada, you may select Geographical Treatment Area B *(worldwide coverage excluding the U.S. and Canada)*. Please note there is no coverage in the U.S. and Canada if you purchase Area B. ***Once a Geographical Treatment Area is purchased, changes are not available on the same certificate.***

****It is your responsibility to maintain all records regarding travel history, age and student status. These may be required by Seven Corners to verify plan eligibility.***

For U.S. Citizens: If you select and purchase coverage in Geographical Treatment Area A, you must either be outside the United States at the time of application or must depart the United States within 30 days of your effective date.

WORLDWIDE COVERAGE (CONT.)

If you select and purchase coverage in Geographical Treatment Area B, you must be outside the United States at the time of application or must depart the United States prior to your effective date.

For Non-U.S. Citizens: If you select and purchase coverage in Geographical Treatment Area A, you are ***not required*** to be outside the United States at the time of application, nor are you required to depart the United States within 30 days of your effective date.

If you select and purchase coverage in Geographical Treatment Area B, you are ***not required*** to be outside the United States at the time of application, nor are you required to depart the United States prior to your effective date.

HOW DO I APPLY FOR COVERAGE?

Simply complete the online application and submit it with your payment. If you would like a paper application, please contact your agent or Customer Service at 1-800-335-0611. We will review your application and request additional information if needed. If you are accepted, you will receive an ID card with your effective date and conditions of acceptance along with a certificate of coverage. The certificate describes the program in detail. If you are not accepted for coverage, Seven Corners will return your premium without delay.

FILING A CLAIM

Simply complete our claim form (available online), sign it, and submit it with itemized bills and receipts (if you already paid for the expenses) to Seven Corners. If acceptable with the facility, we will pay the treating hospital or physician direct.

PRE-NOTIFICATION PROGRAM/PPO

To ensure you receive appropriate care, we require that you or someone on your behalf contact Seven Corners Assist at least 48 hours before receiving medical treatment and no later than 48 hours after an emergency. Contact information for Seven Corners Assist is on your ID Card.

Services and treatment in the U.S. must be received at an approved PPO Service Provider, if available within 50 miles of your location. To obtain a list of approved PPO providers, contact Seven Corners Assist or visit www.sevencorners.com/ppo. If treatment is received from an approved PPO Service Provider while in the U.S., your deductible will be reduced by 50% and your coinsurance will be waived.

YOUR UNDERWRITER

Reside Blue is underwritten by Certain Underwriters at Lloyd's of London. With over 300 years of experience in the international insurance business, Lloyd's is one of the largest insurance entities in the world. Please visit www.lloyds.com for details.

ABOUT **RESIDE® BLUE**

SEVEN CORNERS, PROGRAM ADMINISTRATOR

Seven Corners, Inc.* has administered Reside Blue since its inception. With 20 years of experience, we have the innovative solutions necessary to handle the demands of the international insurance arena. We service thousands of policyholders throughout the world and provide international insurance plans for private citizens, governments, missionaries, students, and corporations. You can feel confident knowing Seven Corners is working for you from the time you complete your application through the claims payment process.

**In California, operating under the name Seven Corners Insurance Services.*

IMPORTANT BENEFIT DETAILS

We offer a variety of benefits with Reside Blue. We highlight a few key coverages below that may be especially important as part of your international health insurance program. For more details, you may review the sample certificate available online.

Preventive Benefits & Child Wellness - We offer coverage for checkups and routine visits for all members after 180 days.

Emergency Medical Evacuation - We will transport you to receive proper care if it is not available in your area. If it is medically necessary, we will return you home.

Emergency Reunion - We will fly a person of your choice to your bedside.

Return of Remains - We will transport your remains home should you die while traveling.

LIMITATIONS

Pre-Existing Conditions: If an existing medical condition is disclosed on your application and not excluded or restricted by a rider, it is covered for a lifetime maximum of $50,000 *($5,000 per Policy Period)*, after you have been continuously insured for two consecutive and continuous policy periods. Otherwise, pre-existing conditions are not covered.

Pre-existing conditions are defined as any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder, regardless of the cause, including any congenital, chronic, subsequent, or recurring complications or consequences related thereto or resulting therefrom that with reasonable medical certainty existed at the time of application or any time prior to your effective date of coverage under this certificate, whether or not previously manifested, symptomatic, known, diagnosed, treated or disclosed. This specifically includes but is not limited to any medical condition, sickness, injury, illness, disease, mental illness or mental nervous disorder for which medical advice, diagnosis, care or treatment was recommended or received, or for which a reasonably prudent person would have sought treatment prior to the effective date of coverage.

LIMITATIONS (CONT.)

Exclusions*: The following conditions, treatments, supplies, services, and/or expenses are not covered.

- Treatment of the following which manifest themselves or are recommended, or in which symptoms occur during the first 180 days of coverage: any breast condition, any prostate condition, reproductive system disorders, gall stones, kidney stones, any acne diagnosis or acne-related condition, any surgery that is not emergency in nature.
- Pre-existing conditions as defined above.
- Expenses for pregnancy within the first 364 days of coverage.
- Claims not presented to us within 90 days of treatment.
- Treatment that is not medically necessary or exceeds reasonable & customary charges; treatment provided at no cost to you; non-medical expenses; treatment performed by a relative or anyone who lives with you; experimental treatment.
- Suicide or attempted suicide; self-inflicted injury or illness.
- War or warlike operations.
- Injuries due to organized, professional, amateur, or interscholastic athletics.
- Temporomandibular joint.
- Flat feet, fallen arches, corns, bunions, calluses, toenails.
- Vocational, occupational, speech, recreational or music therapy.
- Cosmetic surgery unless due to a covered accident.
- Dental or eye treatment unless otherwise covered.
- Injuries/illnesses due to alcohol, chemical, or drug use.
- Telephone consultations or failure to keep an appointment.
- Custodial, rehabilitative, or nursing home care.
- Congenital conditions.
- Expenses in connection with the commission or attempt of a criminal offense.
- Injury while taking part in mountaineering, hang gliding, parachuting, bungee jumping, racing, SCUBA diving *(unless PADI, NAUI, YMCA, SSI or PDIC certified). (A Sports Rider may be purchased to cover certain activities.)*
- Venereal or sexually transmitted disease, HIV, AIDS.
- Treatment, medication, & procedures to promote or prevent conception or childbirth.
- Chronic Fatigue Syndrome; occupational diseases; weight control.
- Pregnancy expenses incurred by a dependent child.

**This is a review of the exclusions in the certificate. This brochure is intended as a brief summary of benefits and services and is not your policy. A complete description of the provisions, benefits, and exclusions are contained in the certificate of coverage, which is provided to you after your coverage has been issued. To view a sample certificate of coverage, go to: www.sevencorners.com/reside-blue/. If there is any difference between this brochure and your certificate of coverage, the provisions of the certificate will prevail.*

WELLABROAD - WWW.WELLABROAD.COM

Wellabroad is our real-time website with medical, political and cultural resources for your use:

- Text messaging alerts - Receive updates on weather, security issues, customs alerts, and health care or pandemic warnings.
- Provider network directory - Create customized country profiles with instant access to providers in your area.

RESIDE® BLUE WORLDWIDE MEDICAL PLAN

Effective September 16, 2013

WORLDWIDE COVERAGE INCLUDING UNITED STATES (GEOGRAPHICAL TREATMENT AREA A)

	If you choose a $250 Policy Period Deductible		If you choose a $500 Policy Period Deductible		If you choose a $1,000 Policy Period Deductible		If you choose a $2,500 Policy Period Deductible		If you choose a $5,000 Policy Period Deductible	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
19 through 29	$1,134	$1,633	$975	$1,502	$780	$1,139	$678	$991	$532	$804
30 through 39	$1,155	$1,776	$993	$1,559	$795	$1,160	$691	$1,009	$543	$819
40 through 44	$1,517	$1,982	$1,388	$1,805	$1,111	$1,332	$956	$1,261	$746	$961
45 through 49	$1,757	$2,125	$1,598	$1,949	$1,231	$1,477	$1,108	$1,329	$903	$1,038
50 through 54	$2,088	$2,251	$1,880	$2,049	$1,504	$1,639	$1,391	$1,516	$1,113	$1,213
55 through 59	$2,720	$2,643	$2,420	$2,348	$1,973	$1,913	$1,666	$1,617	$1,400	$1,358
60 through 64	$3,819	$3,602	$3,571	$3,345	$2,856	$2,642	$2,685	$2,483	$2,255	$1,996
65 through 69	$7,639	$6,868	$7,429	$6,424	$6,891	$5,892	$5,340	$4,913	$4,700	$4,324
70 through 74	**Contact Your Agent or Seven Corners for Rates**									
Dep. Child*	$1,015	$1,015	$873	$873	$698	$698	$604	$604	$472	$472
Child Alone** Age 14 Days to 18	$1,069	$1,069	$919	$919	$735	$735	$636	$636	$497	$497

WORLDWIDE COVERAGE EXCLUDING UNITED STATES (GEOGRAPHICAL TREATMENT AREA B)

	If you choose a $250 Policy Period Deductible		If you choose a $500 Policy Period Deductible		If you choose a $1,000 Policy Period Deductible		If you choose a $2,500 Policy Period Deductible		If you choose a $5,000 Policy Period Deductible	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
19 through 29	$839	$1,209	$721	$1,111	$578	$843	$502	$733	$395	$595
30 through 39	$855	$1,314	$735	$1,154	$588	$859	$511	$747	$401	$607
40 through 44	$1,122	$1,467	$1,027	$1,336	$822	$986	$707	$933	$551	$711
45 through 49	$1,300	$1,573	$1,183	$1,442	$910	$1,093	$820	$984	$668	$769
50 through 54	$1,546	$1,666	$1,391	$1,516	$1,113	$1,213	$1,029	$1,121	$823	$898
55 through 59	$2,013	$1,956	$1,791	$1,738	$1,460	$1,415	$1,234	$1,196	$1,036	$1,005
60 through 64	$2,826	$2,665	$2,642	$2,476	$2,114	$1,955	$1,987	$1,838	$1,670	$1,477
65 through 69	$5,653	$5,082	$5,483	$4,753	$5,099	$4,360	$3,952	$3,636	$3,478	$3,199
70 through 74	**Contact Your Agent or Seven Corners for Rates**									
Dep. Child*	$751	$751	$646	$646	$517	$517	$447	$447	$349	$349
Child Alone** Age 14 Days to 18	$791	$791	$680	$680	$544	$544	$470	$470	$368	$368

PREMIUMS FOR OPTIONAL BENEFITS

AD&D Principal Sum Rider:

Benefit	Annual Premium
$100,000	$143
$200,000	$286
$300,000	$429
$400,000	$572
$500,000	$715
Child $10,000	$15

Dental Rider:

For U.S. Citizens: $359 per person per policy period

For Non-U.S. Citizens: $508 per person per policy period

(if selected for one, then all applicants must purchase the option)

Sports Rider:

$240 per person per policy period

(if selected for one, then all applicants must purchase the option)

Hospital Indemnity Benefit Rider:

$145 per person per policy period

Benefit is $150 per night for a covered hospital admission, maximum 30 nights per policy period.

(if selected for one, then all applicants must purchase the option)

Professional Sailboat Racing Rider:

$250 per person per policy period

Maximum amount payable per policy period of $100,000 for medical expenses.

Pregnancy & Newborn Rider:

$4,000 per person per policy period

(may be selected for females only, for the primary insured or the spouse)

*The Dependent Child Premium is available when at least one parent *(legal guardian)* of a natural or legally adopted unmarried child at least 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 on the same certificate. No medical premium is charged for the first 2 Dependent Children between the ages of 14 days and 9 years old if both parents are also covered under the same certificate. **Children applying without an insured parent or guardian on the same certificate must use the Child Alone rates.

If the Applicant desires to pay premiums in two, four, or twelve installments per policy period, they must do so by credit/debit card payment only. Seven Corners will automatically debit the credit/debit card on the due date of the premium installment. The Premium Installment Factors to be applied to the Annual Premium are as follows:

One Payment per Policy Period 1.00 / Two Payments per Policy Period 0.55 / Four Payments per Policy Period 0.28 / Twelve Payments per Policy Period 0.10

IMPORTANT NOTICE: The premiums referenced above are applicable for the initial 364-day coverage period, after you have been accepted by Seven Corners. Seven Corners reserves the right to increase the stated premiums based upon underwriting & your medical condition at the time of application. Applicants with chronic and/or severe medical conditions may be declined. At each renewal period, Seven Corners will inform you of your renewal premium based upon your age and deductible.

Attention Applicants: Certain Underwriters at Lloyd's of London, operates as an approved Surplus Lines market in most U.S. states. The premiums listed above include Surplus Lines Taxes and Fees where applicable.

RESIDE® BLUE APPLICATION FOR COVERAGE

Reside Blue Worldwide Medical Plan – All Sections Must be Completed in Full

As described in the brochure and documentation, Reside Blue Worldwide Medical Plan is a comprehensive medical insurance program. 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 Blue limits coverage in the United States to 180 days (6 months) during any 364-day 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" is marked must be described in detail in Section 4. This Information 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 Seven Corners.
4. The Premiums listed are Policy Period 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, installment payments (options include two, four, or twelve payments per Policy Period) can be made by using a credit card or ACH payment. The installment payment options are only accepted with Pre-authorization to debit your credit card or checking account on the due date of your premium installment.
5. After Seven Corners underwrites your application and determines that coverage will be issued, we will provide you with an ID Card and a Certificate of Coverage. 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 Seven Corners' Pre-Notification Program.

All Sections Must Be Completed in Full

SECTION 1. PROGRAM OPTIONS

1. Coverage Option:
   - ❑ Worldwide Coverage Including the United States *(Geographical Treatment Area A)* **or**
   - ❑ Worldwide Coverage Excluding the United States (*Geographical Treatment Area B)*

   Be certain to choose the correct premium in your premium calculation. Please note that Worldwide Coverage Excluding the United States excludes any expenses incurred in the United States. After you have made a selection, please keep in mind that you may not alter your coverage location option.
2. Please Choose Your Policy Period Medical Deductible: ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000
3. Would you like to include the Pregnancy and Newborn Benefit Option? ❑ Yes ❑ No
4. Would you like to include the Dental Option? ❑ Yes ❑ No
5. Would you like to include the Sports Option? ❑ Yes ❑ No
6. Would you like to include the Hospital Daily Indemnity Option: ❑ Yes ❑ No
7. Would you like to increase the Accidental Death and Dismemberment Benefit? ❑ Yes ❑ No If yes, to what amount: _____
   Primary Insured ❑ $100,000 ❑ $200,000 ❑ $300,000 ❑ $400,000 ❑ $500,000
   Spouse ❑ $100,000 Child (each child) ❑ $10,000
   What is the Primary Insured's Annual Income? _____
   Accidental Death and Dismemberment (AD&D) benefit is limited to 7 times the Primary Insured's Annual Income for persons under the age of 55. Persons over the age of 55 may be limited to a lesser amount.
8. Would you like to include the Professional Sailboat Racing Rider: ❑ Yes ❑ No

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Requested Effective Date: _____ / _____ / _____ *(month/day/year) (Requested Effective Date must be within 60 days of application date, and U.S. Citizens choosing Worldwide Coverage including the United States, must leave the U.S. within 30 days of effective date. U.S. Citizens choosing Worldwide Coverage excluding the United States, must leave the U.S. prior to the effective date. If accepted, official Effective Date will be advised by Seven Corners.)*

For the AD&D benefit *(including any increased amount)*, please provide the beneficiary:

Primary Insured: _____ Spouse: _____

Child #1: _____ Child #2: _____

Child #3: _____ Child #4: _____

SECTION 2. APPLICANT INFORMATION

Applicant's Name *(Last, First, Middle, Maiden)*	**Sex**	**Relationship**	**Date of Birth** *(MM/DD/YYYY)*	**Citizenship**	**Height** *Feet / Inches*	**Weight** *lbs.*
		Primary				
		Spouse				
		Child #1				
		Child #2				
		Child #3				
		Child #4				

Vessel Information:

Name of Current Vessel and Country of Registry / Flag: _____

Telephone *(if available)*: (____) _____ Fax *(if available)*: (____) _____ Email *(if available)*: _____

Expected time outside U.S. during the next 12 months: _____

Countries to be visited during the next 12 months: _____

My principal residence is onboard the vessel(s) where I am employed ❑ Yes ❑ No

If you answered yes, please complete the Declaration of Residence form attached. If you answered no, please provide a non-US address in the Residence Address section below.

Address of Residence: *(must be outside the United States)*

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Forwarding / Convenience Address:

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Home Phone: (____) _____ Business Phone: (____) _____ Fax: (____) _____ *(please include area and/or country code)*

Email: _____

Occupation of Primary Insured Onboard Vessel(s): _____ Occupation of Spouse: _____

Family Physician Name: _____

Address of Family Physician: _____ Phone: (____) _____

Declaration of Residence

I _____ do hereby declare, attest, certify and warrant that I am employed aboard and/or own and/or operate a registered seagoing vessel, typically spending a significant period of time sailing outside of U.S. territorial Waters.

My principal residence is the non-U.S. address provided on my application or my principal residence is on the internationally traveling vessel. I have supplied within my insurance application a mail forwarding address simply for convenience in sending and receiving mail and other communications, and not with any intent to establish or claim residency.

I understand that this insurance is not subject to individual insurance laws of the United States or of any particular State thereof, and declare that I am waiving any claim to residency in a state of the United States for purposes of this insurance.

_____ _____

Signature Date

YES NO

❑ ❑ 1. Do you understand this is an international program and not U.S. health insurance?

❑ ❑ 2. Do you understand that you are unable to be in the U.S. longer than 180 days (6 months) during any 364-day policy period?

❑ ❑ 3. Are you or any listed dependents currently in the United States? If yes, enter departure date below.

When do you plan to depart the United States: _____ / _____ / _____ *(month/day/year)*

(U.S. Citizens choosing Worldwide Coverage excluding the United States must depart the United States prior to the effective date.)

❑ ❑ 4. Are any listed dependents who are age 19, 20, 21, 22 and 23 full-time students? *(if yes, please list schools and locations)*

_____

SECTION 3. UNDERWRITING QUESTIONS FOR ALL APPLICANTS

In order for your Application to be processed successfully, each question must be answered truthfully for all applicants. Any answers to "yes" questions must be explained in Section 4. Health History Details. In addition, answers to "yes" questions require an Attending Physicians Statement (APS) dated within the past 90 days containing detailed information and medical records.

Within the past ten (10) years, have you or any applicant sought treatment or been advised to seek treatment for, been medically advised, referred, counseled, treated, had surgery, been diagnosed with or are you or any applicant currently taking prescription medicine for: *(Please 'check' all that apply and state detail in Section 4. Health History Details.)*

YES NO

❑ ❑ 1. Digestive system diseases or disorders *(including, but not limited to: gastritis, ulcers, gastroesophageal reflux disease (acid reflux, GERD), hemorrhoids, colon or rectum disorders)*?

❑ ❑ 2. Cardiovascular and/or circulatory diseases or disorders *(including, but not limited to: high or low blood pressure, elevated cholesterol, heart attack, angina, chest pains, arteriosclerosis, coronary insufficiency, thrombosis, phlebitis, vascular afflictions, rheumatic fever, heart murmur, shunts, stents, pacemaker)*? If "Yes" attach Attending Physicians Statement *(APS)* and current blood pressure reading, dated within the past 90 days describing the cardiovascular and/or circulatory condition.

❑ ❑ 3. Respiratory diseases or disorders *(including, but not limited to: chronic cough, bronchitis, tuberculosis, lung disorders, emphysema, respiratory insufficiency, pleurisy, pneumonia, sleep apnea)*?

❑ ❑ 4. Asthma or allergies?
- a) Hospitalization or emergency room treatment? Yes ❑ No ❑
  If yes, how many in last year and date of last incident? _____
- b) Medications: Type: _____ Dosage: _____
- c) Frequency of attacks _____

❑ ❑ 5. Diseases or disorders of the eyes, nose, ears and throat *(including, but not limited to: nasal septum deviation, sinusitis, cataracts, glaucoma, ear infections, TMJ)*?

❑ ❑ 6. Sexually transmitted diseases or immune deficiency disorder *(AIDS/ARC)*, tested positive for HIV or any related illness?

❑ ❑ 7. Diabetes? *(If "Yes", complete the following)*
- a) Diabetic Type: _____ I or _____ II
- b) Date Diagnosed: _____ / _____ / _____ *(MM/DD/YYYY)*
- c) Medications: Type: _____ Dosage: _____
- d) Controlled by diet only? Yes ❑ No ❑
- e) Date of last HbA1c Test: _____ / _____ / _____ *(MM/DD/YYYY)* HbA1c Results (1-10): _____

❑ ❑ 8. Diseases or disorders of the pancreas, liver, gallbladder or endocrine disorders *(including, but not limited to: obesity, pituitary or lymph glands, thyroid or metabolic disorders)*?

❑ ❑ 9. Blood, sugar, and/or protein in urine?

❑ ❑ 10. Diseases or disorders of the mental and nervous system (*including, but not limited to: mental retardation, psychosis, mental or behavioral disorders, Down Syndrome or other chromosome disorders, depression, anxiety, chronic fatigue, eating disorders, autism, obsessive compulsive disorder, attention deficit disorder, adult attention deficit disorder*)?

❑ ❑ 11. Neurological disorders (*including, but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient ischemic attacks*)?

❑ ❑ 12. Have you or any applicant used an illegal drug, had any diagnosis or treatment of an alcohol, chemical or drug dependency, problem or abuse, or been advised to reduce alcohol intake, or had any alcohol, chemical or drug related criminal conviction, moving traffic violation, or driver's license suspension?

❑ ❑ 13. Kidney or urinary tract system diseases or disorders *(including, but not limited to: kidney or bladder stones and infections)*?

❑ ❑ 14. Cell or blood diseases or disorders *(including, but not limited to: cancer, tumors, cysts, polyps or other growths of the internal organs, hepatitis, leukemia or Kaposi's sarcoma)*?

❑ ❑ 15. Diseases or disorders of the skin (*including but not limited to: psoriasis, acne, skin cancer, eczema*)?

❑ ❑ 16. Muscular or skeletal diseases or disorders and inflammation *(including, but not limited to: scoliosis, arthritis, rheumatism, gout, tendonitis, joint or vertebrae disorders, osteoporosis, fibromyalgia, amputation)*?

❑ ❑ 17. Diseases or disorders of the breasts *(including, but not limited to: cysts, nodules, calcifications or abnormal mammogram)*?

❑ ❑ 18. Have you or any applicant consulted a therapist, physician, chiropractor, psychologist, or health care practitioner for medical advice, medical treatment and/or preventative care? Have you or any applicant been hospitalized or undergone medical studies *(including, but not limited to diagnostic tests, x-rays, electrocardiograms, radiology or blood work)*?
- a) If you answered yes to this question, please indicate if you had any abnormal results or were advised to undergo further testing, surgery, or treatment? Yes ❑ No ❑

❑ ❑ 19. For male applicants, diseases or disorders of the reproductive system *(including, but not limited to: prostate or elevated PSA level)*?

❑ ❑ 20. For female applicants, diseases or disorders of the reproductive system *(including, but not limited to: vaginal bleeding, fibroids, nodules, fallopian tubes, ovaries or uterus)*?

SECTION 3. UNDERWRITING QUESTIONS FOR ALL APPLICANTS (CONT.)

YES NO

- ❑ ❑ 21. For female applicants, are you currently pregnant or have had a complicated pregnancy or delivery? If currently pregnant, when is the expected due date? _____ / _____ / _____ *(MM/DD/YYYY)*
- ❑ ❑ 22. In the last 12 months, have you or any applicant used any form of tobacco? If "Yes" what form of tobacco? _____ Who uses? _____ How often: _____
- ❑ ❑ 23. Have you or any applicant had or been recommended to have, or are you currently on a waiting list for an organ transplant?
- ❑ ❑ 24. Have you or any applicant consumed alcoholic beverages in excess of 14 drinks per week? If yes, specify type and how much per week (*one drink equals 12 oz. of beer, 4 oz. of wine, 1 oz. of hard liquor*). _____
- ❑ ❑ 25. In the last 12 months, have you or any applicant experienced a weight gain or loss of 15 pounds or more?
- ❑ ❑ 26. Any Congenital defect, physical disorder or deformity, or developmental problems not listed above?
- ❑ ❑ 27. Are you or any applicant currently hospitalized or scheduled for or in need of hospitalization or surgery, disabled, or unable to perform normal activities?
- ❑ ❑ 28. 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 4. HEALTH HISTORY DETAILS FOR APPLICANTS

List details for all "YES" answers to the Section 3 Underwriting Questions (use additional paper, if necessary). Incomplete answers may delay processing or result in denial of application.

Name of Person and Question #	Condition / Diagnosis, Treatment, Medication Prescribed and Results of Treatment	Duration / Dates of Treatment	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. Have you or any applicant ever been rejected, ridered, cancelled, had coverage rescinded, or had premium increased for any Health, Life or Disability Policy?
- ❑ ❑ 4. Have you or any applicant ever applied for or purchased insurance through Seven Corners?

Name _____ Policy/Certificate Number_____

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 Insureds: _____

Policy Number: _____

Type of Plan: _____

❑ Spouse's employer group plan ❑ Other group plan ❑ Individual plan

Insurance Company: _____ Phone: (____) _____

Effective Date: _____ / _____ / _____ *(MM/DD/YYYY)* Termination Date: _____ / _____ / _____ *(MM/DD/YYYY)*

Reason for termination:

❑ Left employment ❑ Employer canceled plan ❑ Non-Renewal

SECTION 5. DECLARATION AND ENROLLMENT REQUEST/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby apply for the Reside Blue program and for the insurance provided by Certain Underwriters at Lloyd's of London (the "Underwriter"). I hereby subscribe to the Global International Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd's of London.

I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto are complete and true to the best of my knowledge and belief. I understand that my qualification for insurance is based upon my answers and statements herein and that this information may be verified by Seven Corners, Inc. (the "Administrator"). I understand that no one has the authority to exclude or direct me to exclude any information sought by this form. I understand that 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 result in a claim denial or loss of coverage.

I understand that 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, or for a condition that with reasonable medical certainty existed before his or her effective date, according to the pre-existing conditions 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 Seven Corners, Inc. or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to, information about: physical condition(s), health history(ies), avocation(s), age(s), occupation(s), and personal characteristic(s). This authorization includes information about drugs, alcoholism, mental illness, or 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 coverage in the United States is limited to 180 days (approximately 6 months) during any 364-day policy period. I also understand that treatment incurred in the United States will not be covered if I have selected and purchased coverage for Geographical Treatment Area B (worldwide coverage excluding the United States). I also understand that Lloyd's of London operates as a surplus lines insurer in most U.S. states and that claims may not be made against a state guarantee insurance fund. I understand and agree that this program is issued outside the United States and that the coverage may not comply with the minimum requirements set forth by any law or regulation, within or outside the United States.

I understand that this program is not, nor does it intend to be, a general United States health insurance policy. This insurance is not subject to, and does not provide certain insurance benefits required by the United States Patient Protection and Affordable Care Act ("PPACA"). The insurance benefits provided by this policy are stated in your policy documents and do not include any additional benefits required by the PPACA. The PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances, penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. You should consult your attorney, insurance agent, or tax professional to determine if the PPACA's requirements are applicable to you.

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 Applicant or Guardian	Date
Signature of Applicant's Spouse (if applicable)	Date

SECTION 6. PREMIUM AND PAYMENT INFORMATION

Premium is due with the submission of the application.

	OPTIONAL UPGRADES		OPTIONAL UPGRADES		OPTIONAL UPGRADES		
1. Standard Medical Plan:	**2. Increased AD&D:**	**3. Dental:**	**4. Sports:**	**5. Hospital Daily Indemnity:**	**6. Professional Sailboat Racing:**	**7. Pregnancy & Newborn:**	**8. TOTAL:**
Policy Period Premium for each family member from the Premium table.	Policy Period Premium for each family member depending upon Principal Sum selected.	Policy Period Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Policy Period Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Policy Period Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Policy Period Premium for each family member utilizing this rider.	Policy Period Premium for each family member utilizing this rider. *(the female primary insured/ female spouse)*	Add the Premium amounts for each column chosen. Medical is required, the others are optional.
You: $ _______	You: $ _______	You: $ _______	You: $ _______	You: $ _______	You: $ _______	You: $ _______	You: $ _______
Spouse: $ _______	Spouse: $ _______	Spouse: $ _______	Spouse: $ _______	Spouse: $ _______	Spouse: $ _______	Spouse: $ _______	Spouse: $ _______
Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______		Child: $ _______
Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______		Child: $ _______
Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______		Child: $ _______
Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______	Child: $ _______		Child: $ _______
Total 1: $ _____	Total 2: $ _____	Total 3: $ _____	Total 4: $ _____	Total 5: $ _____	Total 6: $ _____	Total 7: $ _____	Total 8: $ _____

[   ] x [   ] = [   ]

Policy Period Premium for all applicants from **TOTAL 8** — Installment Factor (see below) — **Total Initial Payment**

❑ One Payment in Full = 1.00 ❑ Two Payments = 0.55 ❑ Four Payments = 0.28 ❑ Twelve Payments = 0.10

Important: Checks and Money Orders accepted for Premium only from U.S. banks

METHOD OF PAYMENT

❑ Check ❑ Money Order ❑ Visa® ❑ MasterCard® ❑ Discover®/Novus® ❑ American Express® ❑ Diners Club International®

Card Number: [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ][ ] Expiration Date: _______ / _______ (month/year)

Name as it appears on the Card: ________________________________

Daytime Phone: (____) ______________ Alternate Phone Number: (____) ______________

Signature *(Required)*: ________________________________

Billing Address: ________________________________ City/State/Zip: ________________________________

All premium payments must be made in U.S. dollars. Checks must be issued from a U.S. bank and made payable to "Seven Corners." If paying by credit/debit card, I authorize Seven Corners to debit my credit/debit card account for the total amount due. In the event that I have elected to *Pre-Authorize credit/debit card payment installments, I hereby request and authorize Seven Corners to debit my credit/debit card periodically as payment installments become due. This authorization will remain in effect until revoked by me in writing, and until Seven Corners actually receives notice. Coverage purchased by credit/debit card is subject to validation and acceptance by credit/debit card company. *For any installment payment other than once per policy period, I pre-authorize Seven Corners to debit my credit/debit card for the proper installment amount on the due date of the installment. ***Check or money order should be made payable to Seven Corners. 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 Name: Community Insurance Agency, Inc. Seven Corners Agent #: 11576

Address: 425 Huehl Road, Suite# 22-A City/State/Zip: Northbrook, IL 60062

Phone: (1-847-897-5120 Fax: (1-847-897-5130 Email: Info@TravelHealthQuote.us

Agent Certification: I am not aware of any other information that may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this application nor any supplement to the application. I have not advised the Applicant to withhold any information regarding the questions and have advised the Applicant to review the application and the answers recorded to confirm completeness and accuracy.

________________________________ ________________

Signature of Agent Date

Security: Certain Underwriters at Lloyd's of London; Rated"A" (Excellent) by A.M. Best and "A+" (Strong) by Standard & Poor's.

Important Information

It is important to note that Lloyd's of London is an international insurance entity. Lloyd's of London operates as a surplus lines insurer in most U.S. states, and coverage and benefits under Reside Blue are not regulated by any U.S. state insurance department.

The information concerning Reside Blue is not intended to be an offer to sell Reside Blue or a solicitation by Seven Corners, Inc. or Lloyd's of London in any jurisdiction where such an action would be unlawful or in which Seven Corners or Lloyd's of London is not qualified to do so. Reside Blue may not be available in all situations or jurisdictions.

Please mail or fax to:

Seven Corners, Inc.
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Carmel, IN 46032
Fax: 317-575-2870
www.sevencorners.com

ADMINISTERED BY

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www.SevenCorners.com

INSURANCE CARRIER

Certain Underwriters at Lloyd's of London
Rated "A" (Excellent) by A.M. Best and
"A+" (Strong) by Standard & Poor's

This brochure is intended as a brief summary of benefits and services. It is not your policy. If there is any difference between this brochure and your policy, the provisions of the policy will prevail. Benefits and premiums are subject to change.

FOR ADDITIONAL INFORMATION

Community Insurance Agency, Inc.
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Northbrook, IL 60062
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