

# RESIDE<sup>®</sup> PRIME



## WORLDWIDE MEDICAL INSURANCE

Protect Yourself And Your Loved Ones No Matter Where You Live.



SEVENCORNERS

# PRIMARY SCHEDULE OF BENEFITS

This Schedule of Benefits applies for your first three Policy Periods. After completion of three consecutive and continuous Policy Periods, the Extended Coverage Schedule of Benefits applies. 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.
inside of the united states and canada	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.
outside of the united states and canada	After the deductible, we pay 100% of eligible expenses to the policy maximum.
inpatient hospital expenses	Average semi-private room & board; usual, reasonable, & customary physician charges; prescription medications; durable medical equipment; nursing; & x-rays to the policy maximum.
intensive care	Intensive Care room & board; usual, reasonable, & customary physician charges; prescription medications; durable medical equipment; nursing; & x-rays to the policy maximum.
surgery	Usual, reasonable, & customary charges for surgery, physician & anesthetics 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 Benefit Options on the following page for an optional rider to increase this benefit to \$200 per day.
outpatient treatment	Usual, reasonable, & customary charges for emergency treatment; surgery; physician's office; & prescription medication to the policy maximum.
physiotherapy, chiropractic	Up to \$75 per visit, when referred in advance by a physician. Lifetime maximum of \$10,000.
medical supplies	Usual, reasonable, & customary charges to the policy maximum.
ambulance	Usual, reasonable, & customary charges to the policy maximum.
well child care (under age 19)	Up to \$200 per policy period for checkups & routine visits after a 180-day waiting period. Not subject to deductible or coinsurance.
maternity	Usual, reasonable, & customary to the limits below per pregnancy. You must pre-notify within the first 90 days of pregnancy. Waiting period of 364 days. <ul style="list-style-type: none"><li>• After completion of 1 continuous policy period: \$1,000</li><li>• After completion of 2 continuous and consecutive policy periods: \$2,000</li><li>• After completion of 3 continuous and consecutive policy periods: \$3,000</li><li>• After completion of 4 continuous and consecutive policy periods: \$4,000</li><li>• After completion of 5 continuous and consecutive policy periods: \$5,000</li></ul>
newborn benefit	Maximums listed below per pregnancy for the first 31 days after birth. <ul style="list-style-type: none"><li>• After completion of 1 continuous policy period: \$1,000</li><li>• After completion of 2 continuous and consecutive policy periods: \$2,000</li><li>• After completion of 3 continuous and consecutive policy periods: \$3,000</li><li>• After completion of 4 continuous and consecutive policy periods: \$4,000</li><li>• After completion of 5 continuous and consecutive policy periods: \$5,000</li></ul>
mental & nervous	Usual, reasonable, & customary to \$10,000 per policy period after a 364-day waiting period. Inpatient limited to 45 days per policy period. Outpatient limited to 40 visits per policy period at 70% of eligible expenses. Lifetime maximum of \$30,000.

# PRIMARY SCHEDULE OF BENEFITS

dental	\$500 per policy period for usual, reasonable, & customary charges for repair & replacement of sound, natural teeth damaged in an accident. An optional Dental Rider may be purchased. Please see details in this brochure.
emergency medical evacuation	\$250,000 per person per policy period, when adequate medical facilities or treatment are not available ( <i>Pre-approval required</i> ).
repatriation/return of remains	\$25,000 per person ( <i>Pre-approval required</i> ).
emergency medical reunion	\$10,000 per person per occurrence ( <i>Pre-approval required</i> ).
preventive benefits (age 19 and over)	\$175 per policy period for checkups & routine physical exams for all members & female preventative exams & mammograms after a 180-day waiting period. Not subject to deductible or coinsurance.
accidental death & dismemberment (ad&d)	24-Hour AD&D: Principal Sum: \$10,000 for insured & spouse, \$2,000 for dependent children. Common Carrier AD&D: Principal Sum: \$40,000 for insured & spouse, \$8,000 for dependent children. To increase this benefit, please see Benefit Options below.
lifetime transplant benefit	Up to \$1,000,000 per insured person.

## BENEFIT OPTIONS

Seven Corners offers optional benefits to enhance your coverage. These cannot be purchased independently.	
ad&d principal sum rider	A standard accidental death & dismemberment (AD&D) benefit is provided. Additional amounts include \$100,000; \$200,000; \$300,000; \$400,000 or \$500,000 for the primary insured (these amounts may not exceed 7 times annual income), \$100,000 for the spouse, and \$10,000 for each child.
dental rider	Optional worldwide dental coverage. Please see details included later in this brochure.
sports rider	\$25,000 lifetime maximum for mountaineering up to 4500 meters where ropes or guides are normally used, hang gliding, 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 ( <i>in addition to the standard benefit of \$50</i> ) 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.

## SEVEN CORNERS ASSIST

### When Unpronounceable Diseases Occur In Unpronounceable Countries - We are Here to Help!

Our multilingual Seven Corners Assist team is a leading provider of 24/7 customized emergency assistance services to international organizations, corporations, government entities, insurance companies, and individual travelers.

#### 24/7 Assistance With Travel:

We can provide local weather details, currency rates, embassy contact information, contact information for interpreters, guidance for lost passport recovery, and pre-trip information including inoculation and visa requirements.

#### 24/7 Medical Assistance While Traveling

We can locate appropriate medical care; arrange phone conferences between your attending and home physicians; arrange second opinions; relay emergency messages; provide medical bill payment guarantees, medical benefit authorizations, 24-hour ticketing for emergency family visits; arrange emergency medical evacuations, medical transportation home after treatment, escorts & transportation for unaccompanied children; medical records transfers; and return of remains for deceased travelers.

# DESCRIPTION OF BENEFITS

## WHY CHOOSE RESIDE PRIME?

Reside Prime is intended for persons who live or travel outside the United States. It's the health insurance solution for you and your family if you are:

- a U.S. citizen relocating or spending extended time overseas.
- a foreign national needing protection in your home country and while traveling abroad.

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. If you are insured for more than three consecutive policy periods, the Extended Coverage Schedule of Benefits applies. Please see this schedule provided later in this brochure.

## WORLDWIDE COVERAGE

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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.***

## 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/networkproviders](http://www.sevencorners.com/networkproviders). 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 Prime is underwritten by Certain Underwriters at Lloyd's of London and Tramont Insurance Company Limited. Both companies have the experience and financial strength to provide the security you need in a health insurance provider. Your residence address determines which one provides your coverage. Pricing and benefits are identical for both companies.

Lloyd's of London has over 300 years of experience in the international insurance business and is one of the largest insurance entities in the world. Please visit [www.lloyds.com](http://www.lloyds.com) for details. Tramont Insurance Company Limited is a worldwide insurer with the expertise to provide quality international health insurance. For details regarding Tramont, please visit [www.tramontinsurance.com](http://www.tramontinsurance.com).

## SEVEN CORNERS, PROGRAM ADMINISTRATOR

Seven Corners, Inc.\* has administered Reside Prime 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 Prime. We highlight a few key coverages that may be especially important as part of your international health insurance program. For more details, you may review the sample certificate available online.

# DESCRIPTION OF BENEFITS

## IMPORTANT BENEFIT DETAILS (CONT.)

**Maternity** - Reside Prime provides maternity and newborn coverage. A pregnancy must be pre-notified during the first 90 days. Expenses related to a pregnancy are not covered within the first 364 days of coverage.

**Newborn children** are automatically covered for the first 31 days after birth, if the mother remains eligible for coverage and her pregnancy is covered. To extend coverage, we must receive the newborn's application and premium within 31 days of birth. Based on the application, riders limiting or excluding medical conditions and/or body parts may be required.

**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.

**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.

## LIMITATIONS (CONT.)

- 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-prime/](http://www.sevencorners.com/reside-prime/). 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.
- Online forums - Fellow travelers and Seven Corners' staff post experiences and travel tips.



# EXTENDED COVERAGE SCHEDULE OF BENEFITS

After the completion of three policy periods, the following schedule of benefits applies beginning on the 1st day of your fourth policy period. Below is a listing of the benefits that will be adjusted with this change in schedules. If not listed below, the benefit will remain the same as the Primary Schedule of Benefits. All other conditions of the policy continue to apply.

<b>lifetime maximum benefit</b>	\$2,500,000 per insured person.
<b>policy period deductible options</b>	Deductibles will be increased by \$250 as follows: \$250 becomes \$500; \$500 becomes \$750; \$1,000 becomes \$1,250; \$2,500 becomes \$2,750; \$5,000 becomes \$5,250 Maximum of 3 deductible payments for families enrolling on one application.
<b>inpatient hospital expenses</b>	Average semi-private room and board; usual, reasonable, and customary physician charges; prescription medications; durable medical equipment; nursing services; and x-rays. These benefits are covered to the policy maximum with a limit of \$2,000 per day.
<b>intensive care</b>	Intensive Care room and board; usual, reasonable, and customary physician charges; prescription medications; durable medical equipment; nursing services; and x-rays. These benefits are covered to the policy maximum with a limit of \$4,000 per day.
<b>outpatient treatment</b>	Usual, reasonable, and customary charges for emergency treatment; surgery; physician's office; & prescription medication to the policy maximum. <ul style="list-style-type: none"><li>- physician charges, limit of \$150 per visit</li><li>- hospital charge, \$100 co-pay unless admitted, then waived</li><li>- urgent care facility, \$25 co-pay</li><li>- diagnostic lab and x-rays, limited to \$5,000 per policy period</li></ul>
<b>physiotherapy, chiropractic</b>	Up to \$75 per visit, when referred in advance by a physician. Maximum of \$1,000 per policy period & lifetime maximum of \$10,000.
<b>medical supplies</b>	Usual, reasonable, and customary charges to the policy maximum.
<b>ambulance</b>	\$100 per incident.
<b>mental &amp; nervous</b>	\$2,000 maximum per policy period. Inpatient limited to 25 days per policy period. Outpatient limited to 20 visits per policy period at 70% of eligible expenses, up to \$75 maximum per visit. Lifetime maximum of \$30,000.
<b>repatriation/return of remains</b>	\$15,000 limit per person ( <i>Pre-approval required</i> ).
<b>lifetime transplant benefit</b>	\$500,000 per insured person.
<b>chemotherapy or radiation therapy</b>	\$10,000 per policy period, lifetime maximum of \$50,000.
<b>outpatient prescription medications</b>	Limit of \$5,000 per policy period for each insured person.

**Important Information**  
*Lloyd's of London and Tramont Insurance Company Limited are international insurance entities, and Reside Prime is not regulated by any U.S. state insurance department. Lloyd's of London operates as a surplus lines insurer in most U.S. states. Tramont Insurance Company Limited operates as an authorized insurer worldwide (coverage with Tramont cannot be initiated or purchased in the British Virgin Islands, U.S. Virgin Islands, and the United States, although you are covered in these areas per the plan provisions). The information concerning Reside Prime is not intended to be an offer to sell Reside Prime or a solicitation by Seven Corners, Inc., Lloyd's of London, or Tramont Insurance Company Limited in any jurisdiction where any such sale would be unlawful, or in which Seven Corners, Lloyd's of London, and Tramont Insurance Company Limited are not qualified to do so. Reside Prime may not be available in all situations or jurisdictions.*

# OPTIONAL DENTAL COVERAGE

**Benefits (covered for usual, reasonable, and customary cost)**

**class I: preventative**

- Two oral exams per policy period
- One set of full mouth x-rays every 180 days
- One set of bitewing x-rays per policy period
- One cleaning & scaling of teeth (oral prophylaxis) every 180 days
- One topical fluoride treatment per policy period for insured persons under 19 years
- Space maintainers for insured persons under 19 years of age
- Sealants for children up to & including age 12

**class II: basic restoration, endodontic, periodontal, oral surgery, diagnostic benefit dental services**

- Fillings – amalgam, silicate, acrylic, synthetic porcelain or composite fillings
- X-rays, extractions, root canals, emergency palliative treatment, injections of antibiotics
- Treatment of periodontal disease & other gum & mouth tissue disease
- Oral surgery except procedures covered under any medical plan
- Administration of general anesthesia, when medically necessary during oral surgery

**class III: crowns, bridges, dentures**

Installation or replacement of 1 or more natural teeth which are lost for:

- Initial Installation of fixed bridgework and installation for the first time of a partial removable denture or full removable denture
- Replacement of an existing removable denture or fixed bridgework
- Replacement of an existing immediate temporary full denture by a new permanent full denture
- Adding teeth to an existing partial removable denture or to bridgework
- Inlays and onlays
- Crowns and their replacements (not more than 1 replacement per crown every 5 years)
- Repair or re-cementing of crowns; or inlays or onlays; or dentures; or bridgework

If dental expenses are expected to exceed \$250, you must pre-notify Seven Corners before treatment. For a complete itemization of benefits and a listing of exclusions, please see [www.sevencorners.com/downloads/brochures/ResidePrimeDental\\_BR.pdf](http://www.sevencorners.com/downloads/brochures/ResidePrimeDental_BR.pdf)

Benefit (covered for usual,reasonable, and customary cost)	Policy Period 1	Policy Period 2	Policy Period 3 and after
<b>class I preventative benefits</b> (90-day waiting period)	100%	100%	100%
<b>class II standard benefits</b> (180-day waiting period)	55%	70%	85%
<b>class III significant dental benefits</b> (180-day waiting period)	30%	40%	50%
<b>deductible</b> (per person per policy period)	\$100	\$100	\$100
<b>maximum benefit</b> (per person per policy period)	\$500	\$750	\$1,000

# RESIDE®PRIME WORLDWIDE MEDICAL PLAN

Premiums shown below are for the entire 364-day Policy Period. Rates effective January 1, 2012

WORLDWIDE COVERAGE INCLUDING UNITED STATES AND CANADA (GEOGRAPHICAL TREATMENT AREA A)										
	Policy Period Premium \$250 Policy Period Deductible		Policy Period Premium \$500 Policy Period Deductible		Policy Period Premium \$1000 Policy Period Deductible		Policy Period Premium \$2500 Policy Period Deductible		Policy Period Premium \$5000 Policy Period Deductible	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
19 through 29	\$1,021	\$1,597	\$886	\$1,422	\$709	\$1,029	\$613	\$885	\$481	\$753
30 through 39	\$1,101	\$1,763	\$942	\$1,588	\$762	\$1,150	\$662	\$1,010	\$520	\$838
40 through 44	\$1,467	\$1,989	\$1,342	\$1,747	\$1,073	\$1,345	\$924	\$1,223	\$721	\$1,057
45 through 49	\$1,698	\$2,039	\$1,531	\$1,885	\$1,182	\$1,474	\$1,063	\$1,307	\$869	\$1,082
50 through 54	\$2,019	\$2,219	\$1,809	\$2,033	\$1,445	\$1,619	\$1,338	\$1,459	\$1,074	\$1,176
55 through 59	\$2,629	\$2,554	\$2,327	\$2,319	\$1,900	\$1,773	\$1,609	\$1,564	\$1,350	\$1,308
60 through 64	\$3,693	\$3,496	\$3,453	\$3,215	\$2,747	\$2,552	\$2,591	\$2,406	\$2,178	\$1,915
65 through 69	\$7,386	\$6,641	\$7,125	\$6,242	\$6,622	\$5,675	\$5,119	\$4,724	\$4,496	\$4,144
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child*	\$970	\$970	\$842	\$842	\$674	\$674	\$582	\$582	\$457	\$457
Child Alone** Age 14 Days to 18	\$1,021	\$1,021	\$886	\$886	\$709	\$709	\$613	\$613	\$481	\$481

WORLDWIDE COVERAGE EXCLUDING UNITED STATES AND CANADA (GEOGRAPHICAL TREATMENT AREA B)										
	Policy Period Premium \$250 Policy Period Deductible		Policy Period Premium \$500 Policy Period Deductible		Policy Period Premium \$1000 Policy Period Deductible		Policy Period Premium \$2500 Policy Period Deductible		Policy Period Premium \$5000 Policy Period Deductible	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
19 through 29	\$771	\$1,206	\$670	\$1,074	\$535	\$776	\$463	\$669	\$363	\$569
30 through 39	\$815	\$1,304	\$697	\$1,175	\$563	\$851	\$490	\$748	\$385	\$620
40 through 44	\$1,093	\$1,482	\$999	\$1,302	\$799	\$1,002	\$689	\$911	\$537	\$788
45 through 49	\$1,256	\$1,509	\$1,133	\$1,395	\$874	\$1,092	\$787	\$967	\$643	\$801
50 through 54	\$1,524	\$1,676	\$1,365	\$1,535	\$1,091	\$1,223	\$1,010	\$1,102	\$810	\$888
55 through 59	\$1,972	\$1,915	\$1,745	\$1,739	\$1,425	\$1,329	\$1,207	\$1,173	\$1,013	\$980
60 through 64	\$2,751	\$2,605	\$2,573	\$2,395	\$2,046	\$1,901	\$1,930	\$1,793	\$1,624	\$1,427
65 through 69	\$5,465	\$4,914	\$5,273	\$4,620	\$4,901	\$4,199	\$3,788	\$3,496	\$3,327	\$3,067
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child*	\$732	\$732	\$637	\$637	\$508	\$508	\$440	\$440	\$345	\$345
Child Alone** Age 14 Days to 18	\$771	\$771	\$670	\$670	\$535	\$535	\$463	\$463	\$363	\$363

PREMIUMS FOR OPTIONAL BENEFITS										
AD&D Principal Sum Rider:			Dental Rider:			Sports Rider:			Hospital Indemnity Rider:	
Benefit	Policy Period Premium		U.S. Citizens: \$359 per person per policy period  Non-U.S. Citizens: \$508 per person per policy period  <i>(if selected for one, then all applicants must purchase)</i>			\$240 per person per policy period  <i>(if selected for one, then all applicants must purchase)</i>			Benefit is an additional \$150 per night for a covered hospital admission, maximum 30 nights per policy period.  \$145 per person per policy period  <i>(if selected for one, then all applicants must purchase)</i>	
\$100,000	\$143	Primary Insured &/or Spouse								
\$200,000	\$286	Primary Insured Only								
\$300,000	\$429	Primary Insured Only								
\$400,000	\$572	Primary Insured Only								
\$500,000	\$715	Primary Insured Only								
\$10,000	\$15	Child								

\* The Dependent Child Premium is used when at least one parent (legal guardian) of a natural or legally adopted unmarried child at least 14 days old & under 19 years of age (or under 24 years if attending a university full-time and relying on parents for support) is also covered under the same program. \*\*Children applying without an insured parent or guardian on the same program must use the Child Alone rates.

If you wish to pay premiums in installments, you must pay by credit/debit card. Seven Corners will automatically debit the card on the due date of your installment. The Premium Installment Factors to be applied to the Total Premium are as follows:

**1 Payment per Policy Period 1.00 / 2 Payments per Policy Period 0.55 / 4 Payments per Policy Period 0.28 / 12 Payments per Policy Period 0.10**

**IMPORTANT NOTICE:** *The premiums shown above are for your first 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 on 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. For Tramont Insurance Company Limited, the premiums listed above include an Administrative Fee.



# NOTES

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# RESIDE® PRIME APPLICATION FOR COVERAGE

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

As described in the brochure and documentation, Reside Prime 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 Prime limits coverage in the United States to 180 days during any given 364-day 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. Information must include the applicant's name, physician's name, address and phone number, 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.
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/debit card or ACH payment. The installment payment options are only accepted with Pre-authorization to debit your credit/debit card or checking account on the due date of your premium installment.
5. After Seven Corners reviews your Application and determines that coverage should be issued, we will provide you with an ID Card and a Certificate of Coverage, underwritten by either Lloyd's of London or Tramount Insurance Company Limited. Your residence address determines which insurance carrier will provide your coverage. Pricing and benefits are identical for both Lloyd's of London and Tramount. The Certificate of Coverage contains all coverage details. You will also receive 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 and Canada (*Geographical Treatment Area A*) **or**  
☐ Worldwide Coverage Excluding the United States and Canada (*Geographical Treatment Area B*)

**Be certain to choose the correct premium in your premium calculation. Please note that Worldwide Coverage excluding the United States and Canada excludes any expenses incurred in the United States and Canada. 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 Dental Option: ☐ Yes ☐ No

#### 4. Would you like to include the Sports Option: ☐ Yes ☐ No

#### 5. Would you like to include the Hospital Daily Indemnity Option: ☐ Yes ☐ No

#### 6. 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.

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (month/day/year) (*Requested Effective Date must be within 60 days of application date.*

*If the Insured Person chooses Worldwide Coverage including the United States and Canada, they must leave the U.S. within 30 days of the Effective Date for coverage with Lloyd's; for Tramount the Insured Person may not be in the U.S. at the time of application or on the Effective Date. If the Insured Person chooses Worldwide Coverage excluding the United States and Canada, they must leave the U.S. prior to the effective date for both Lloyd's and Tramount. In addition, for Tramount, they may not be in the U.S. at the time of application. 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:**

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

**Address of Residence:**

Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

*(If your residence address is outside of the United States, all policy documents will be provided electronically. Please contact Seven Corners for any questions.)*Phone: ( \_\_\_\_ ) \_\_\_\_\_ Business Phone: ( \_\_\_\_ ) \_\_\_\_\_ Fax: ( \_\_\_\_ ) \_\_\_\_\_  
*(please include area and/or country code)*

Email: \_\_\_\_\_

Occupation of Primary Insured: \_\_\_\_\_  
*(If retired, previous occupation(s))*

Name of Employer: \_\_\_\_\_

Duties of Occupation: \_\_\_\_\_

Occupation of Spouse: \_\_\_\_\_

Family Physician Name: (Required) \_\_\_\_\_

Physician Name who performed your last physical: \_\_\_\_\_  
*(If different from Family Physician)***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 during any given 364-day 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)*
- ☐ ☐ 4. Are any listed dependents who are age 19, 20, 21, 22 and 23 full-time students? *(if yes, please list schools and locations)*  
\_\_\_\_\_
- ☐ ☐ 5. Do you understand that the Extended Coverage Benefit Schedule will begin after you have been covered continuously for three Policy Periods? On the first day of the fourth Policy Period, the Extended Coverage Benefit Schedule will begin.

### 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 in 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 within the last year and date of last incident? \_\_\_\_\_
  - b) Medications: Type: \_\_\_\_\_ Dosage: \_\_\_\_\_
  - c) Frequency of attacks \_\_\_\_\_
- ☐ ☐ 5. Diseases or disorders of the eyes, nose, ears, mouth, throat or jaw *(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, anemia, or Kaposi’s sarcoma)?*
- ☐ ☐ 15. Diseases or disorders of the skin *(including, but not limited to: psoriasis, skin cancer, acne, 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? If yes, please provide detail in section 4.
- ☐ ☐ 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.)

- ☐ ☐ 21. For female applicants, are you currently pregnant or have you 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, Medications Prescribed and Results of Treatment	Duration/Dates of Treatment	Physician/Clinic Address and Telephone #

#### INFORMATION ABOUT PRIOR/OTHER COVERAGE

##### YES NO

- ☐ ☐ 1. Have you or any applicant ever applied for or purchased insurance through Seven Corners?  
Name \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_
- ☐ ☐ 2. Have you been covered by another medical plan at any time during the past year?
- ☐ ☐ 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. Will you be covered under any other medical plan (*individual or group*) while you are covered under this plan?  
*For all "YES" answers to questions 2 through 4, please provide the following information. If more than one situation applies, attach a separate piece of paper to describe each situation.*
- Name of Insured(s): \_\_\_\_\_
- 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 Prime program and for the insurance provided by 1) Certain Underwriters at Lloyd's of London (the "Underwriter") for which 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 and 2) Tramont Insurance Company Limited (the "Underwriter") for which I hereby enroll in the group coverage for which I am eligible under the group contract issued by Tramont Insurance Company Limited.

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, alcohol, 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, the 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 during any given 364-day period. I also understand that treatment incurred in the United States and Canada will not be covered if I have selected and purchased coverage for Geographical Treatment Area B (worldwide coverage excluding the United States and Canada).

I also understand that Lloyd's of London operates as a surplus lines insurer in most U.S. states, and Tramont Insurance Company Limited operates as an authorized insurer worldwide (coverage on Tramont cannot be initiated and purchased in the British Virgin Islands, U.S. Virgin Islands, and the United States, although coverage is provided in these areas per the plan requirements). Claims may not be made against a state guarantee insurance fund for either insurance carrier. I understand and agree that this program is issued outside the United States, and 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.

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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.

1. Standard Medical Plan:	2. Additional AD&D Rider (see Section 1 details):	3. Dental Rider:	4. Sports Rider:	5. Hospital Daily Indemnity Rider:	6. 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).	Add the Premium amounts for each column chosen. Medical is required, the others are optional.
Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____	Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____ 4th Child: \$ _____
Subtotal A: \$ _____	Subtotal B: \$ _____	Subtotal C: \$ _____	Subtotal D: \$ _____	Subtotal E: \$ _____	Total F: \$ _____

<div></div>	x	<div></div>	=	<div></div>
Policy Period Premium for all applicants from TOTAL F		Installment Factor (see below)		Total Initial Payment

Installment Factor:

☐ 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 from U.S. banks only**

### 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 or 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 the 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 answers to 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 or Tramount Insurance Company Limited.

#### Important Information

It is important to note that Lloyd's of London and Tramount Insurance Company Limited are international insurance entities. Lloyd's of London operates as a surplus lines insurer in most U.S. states. Tramount Insurance Company Limited operates as an authorized insurer worldwide (coverage cannot be initiated and purchased in the British Virgin Islands, U.S. Virgin Islands, and the United States, although coverage is provided in these areas per the plan provisions). Coverage and benefits under Reside Prime are not regulated by any U.S. state insurance department.

The information concerning Reside Prime is not intended to be an offer to sell Reside Prime or a solicitation by Seven Corners, Inc. or Lloyd's of London, or Tramount Insurance Company Limited in any jurisdiction where such an action would be unlawful or in which Seven Corners, Lloyd's of London, or Tramount Insurance Company Limited is not qualified to do so. Reside Prime may not be available in all situations or jurisdictions. Reside Prime is intended for persons living or traveling outside the United States.

#### Please mail or fax to

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

## ADMINISTERED BY



**SEVEN CORNERS**

303 Congressional Boulevard  
Carmel, IN 46032  
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[www.SevenCorners.com](http://www.SevenCorners.com)



## INSURANCE CARRIER

**Certain Underwriters at Lloyd's of London  
Tramont Insurance Company Limited**

Countries not underwritten by Certain Underwriters at Lloyd's of London are underwritten by Tramont Insurance Company Limited. Please contact Seven Corners for a listing of those countries.

*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.  
425 Huehl Road, Suite# 22-A  
Northbrook, IL 60062  
United States Of America  
EMAIL: [Info@TravelHealthQuote.us](mailto:Info@TravelHealthQuote.us)  
[www.travelhealthquote.us](http://www.travelhealthquote.us)  
T: 1-800-344-9540  
P: 1-847-897-5120  
FAX: 1-847-897-5130