Signature Healthcare Application

Please submit this form and all related correspondence to:

Ramesh Patel
Community Ins Agency, Inc
425 Huehl Rd Suite# 22-A
Northbrook, IL 60062

Phone 1: 800-344-9540
Phone 2: 847-897-5120
Fax: 1-847-897-5130
Email: ramesh@visitorsinsurance.com
Website: www.TravelHealthQuote.us

A. INSTRUCTIONS

1. Please print or type. Read all agreement terms carefully and complete all sections. If space provided is insufficient, please attach additional sheet(s) of paper and sign the application.
2. If you are signing for the applicant, please provide power of attorney documents with the application.
3. Enter the name of those family members currently eligible for coverage.
4. Enclose first payment with the application.
5. All payments should be made payable to: WEA, Ltd.

B. PERSONAL INFORMATION

Applicant's Name (Last, First, MI)

Nationality

Gender ☐ M ☐ F

Passport or Federal ID

Date of Birth MM/DD/YYYY

Host Country

Occupation

Claims Mailing Address: *This address will be used to send all policy documents and claim reimbursements.*

Address (Street and number)

City

State

Country

Postal Code

Home Phone Number

Email Address

C. INSURED INFORMATION

Please complete all information below for you and your dependents. If there is not enough space provided, attach an additional page.

Print full name of individuals to be insured	Relationship	Nationality	ID Number	Sex M/F	Date of Birth	Full Time Student (Y/N)	Height Ft. In.	Weight Lbs.
					MM/DD/YYYY			
					MM/DD/YYYY			
					MM/DD/YYYY			
					MM/DD/YYYY			
					MM/DD/YYYY			

FOR OFFICE USE ONLY

Date Received

Effective Date

First Year Rates

Spouse

Number of Children

D. OTHER HEALTH CARE COVERAGE

Do you (or any dependents listed on this application) have other medical insurance coverage? Yes ☐ No ☐

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

Telephone Number

Who is insured?

☐ Yourself ☐ Spouse ☐ Dependent Children

Policy Number

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

E. COVERAGE SELECTION INFORMATION

Requested Effective Date

MM/DD/YYYY

Plan Option: ☐ CARE Option ☐ SELECT Option ☐ ELITE Option

Deductible Option: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Area of Coverage: ☐ Worldwide ☐ Excluding the U.S.

Optional Maternity Rider ($2,500): ☐ Yes ☐ No

(*Available on CARE & SELECT options only. ELITE option includes maternity benefits*)

Life Insurance (optional):

All plans offer life and accidental death and disability coverage on the primary insured only. Please select from the following face amounts:

Amount of Life Cover: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

Primary Beneficiary

Relationship

Secondary Beneficiary

Relationship

F. HEALTH RELATED INFORMATION

(False or incomplete information will void health coverage)

If any of the following are answered as **NO**, please provide details in section **G**.

	Yes	No	
1.	☐	☐	Do all dependent children live in your household?
2.	☐	☐	Do all dependent children depend on you solely for support?
3.	☐	☐	If any dependent child is age 19 or older, are they regularly attending school?

If any of the following are answered as **YES**, please provide details in section **G**.

	Yes	No	
4.	☐	☐	Is any individual pregnant?
5.	☐	☐	Are there any inpatient or outpatient medical or dental procedures (including diagnostic testing) recommended or contemplated?
6.	☐	☐	Is any individual currently taking medication(s) for any condition? If "Yes", list individual(s), medication and dosage, and indicate duration of use and underlying condition.

F. HEALTH RELATED INFORMATION (continued)

If any of the following are answered as **YES**, please provide details in section **G**.

	Yes	No		
7.	☐	☐	Do you use tobacco products? (If Yes, how many packs of cigarettes per day ☐ and number of years smoked ☐.)	
	Yes	No	*Within the Past*	*Has any Individual*
8.	☐	☐	5 years	Been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner? If "Yes," please explain.
9.	☐	☐	5 years	Been confined to a hospital, clinic, sanitorium or other medical facility? If "Yes," please explain.
10.	☐	☐	10 years	Been denied life, disability, medical or dental coverage? If "Yes," please explain.
11.	☐	☐	10 years	Been denied group coverage? If "Yes," please explain.

Please give complete dates and details for all medical impairments checked using the space provided in section **G**.

	Yes	No	
12.	☐	☐	Within the past 10 years, has there been any disease/impairment of or treatment for any individual for any of the following? If "Yes," check the appropriate box(es) below. Please give complete dates and details for all medical impairments checked using the space provided in section G.

☐ AIDS/AIDS Related Complex	☐ Cancer	☐ Immune System Disorder	☐ Rheumatic fever
☐ Alcoholism	☐ Carpal Tunnel Syndrome	☐ Intestine	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Kidney/Bladder	☐ Skin
☐ Asthma	☐ Ears	☐ Liver	☐ Stroke
☐ Back/Spine/Neck	☐ Epilepsy	☐ Lungs	☐ Substance Abuse
☐ Blood Pressure	☐ Eyes	☐ Mental/Nervous Disorder	☐ Surgical Procedure
☐ Blood Vessels	☐ Gastrointestinal Disorder	☐ Nervous System	☐ Thyroid
☐ Bones	☐ Heart	☐ Paralysis	☐ Tumor or Growth
☐ Brain	☐ Hernia	☐ Reproductive System Disorder	☐ Ulcer

Yes	No	
☐	☐	Does any individual(s) have a known physical impairment(s) or ill health not mentioned above? If "Yes," give complete dates and details.

Dental Questions:

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

13.	Yes	No		Yes	No	
	☐	☐	Any fillings needed? If "Yes," how many? ☐	☐	☐	Any teeth need extraction?
	☐	☐	Any crowns needed?	☐	☐	Periodontal disease needing treatment?
	☐	☐	Any denture/bridge work needed?	☐	☐	Any orthodontic treatment needed?
	☐	☐	Missing teeth needing replacement?	☐	☐	Any surgery needed?
	☐	☐	Periapical disease (i.e., root canal) needing treatment?	☐	☐	Other? ☐
	☐	☐	Have all individual(s) had a dental exam within the last 12 months? If "No," give details.			

G. ADDITIONAL INFORMATION

Please use this section to provide additional information for questions answered in section F. Please provide detailed information including physician name, dates of service, diagnosis and/or treatment(s). Please specify the name of the individual(s) to whom each situation described applies.

☐ Check here if you are providing additional information on a seperate attachment.

H. GENERAL NOTES

I. JOINDER AND PARTICIPATION AGREEMENT

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I will inform WEA, Ltd. of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for coverage and I acknowledge that I have been given the option to print via PDF a copy of this document as completed by me.

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

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide WEA, Ltd. and their representatives, information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) days from the date signed. I agree that a photographic copy of this authorization is as valid as the original.

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

Applicant or Authorized Person's Signature

Date Signed
MM/DD/YYYY

Applicant or Authorized Person's Position and Title

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

Date Signed
MM/DD/YYYY

WEA, LTD. USE ONLY

Administrator Signature

Date Processed
MM/DD/YYYY

J. PREMIUM PAYMENT OPTIONS

A check payable to **WEA, Ltd** for the first month's premium or a credit card authorization must be included with this application. We cannot process any applications without the deposit premium. We will not cash any checks or process any credit cards until the policy has been approved.

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

$

Policy Holder $

Spouse $

1st Dependent Child $

2nd Dependent Child $

3rd Dependent Child $

4th Dependent Child $

C. Optional Term Life & AD&D

- ☐ $10,000 ($40 annual)
- ☐ $25,000 ($100 annual)
- ☐ $50,000 ($200 annual)
- ☐ $75,000 ($300 annual)
- ☐ $100,000 ($400 annual)

A. Sub Total $

B. ☐ Optional Maternity Rider $2,500 (Available on CARE and SELECT options only). ELITE option includes maternity benefits.

D. Payment Factors

- ☐ Annual (X 1)
- ☐ Quarterly (X 0.28)
- ☐ Semi-Annual (X 0.55)
- ☐ Monthly (X 0.10)

A. + B. (if chosen) + C. (if chosen) + $35 Policy fee X D. = $ Total Premium Due

CREDIT CARD PAYMENTS

Billing Address

Name

Street

City State Postal Code

Phone 1 Phone 2

Fax Email

Overseas Communications

Name

Street

City Country Postal Code

Phone 1 Phone 2

Fax Email

Credit Card Authorization: ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number

Name as it appears on card

Daytime Phone

Expiration Date MM/DD/YYYY

CVV Code

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

Signature

Signature Healthcare Application

K. PRODUCER INFORMATION

Producer Code

WE100142

Producer Name

Ramesh Patel

Agency

Community Ins Agency, Inc

Email

ramesh@visitorsinsurance.com

Address

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

Signature

Ramesh Patel