WellAway

Keeping You Well, While You're Away.®

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ORBE Enrollment Application

*Requested coverage start date: ______________ Quote Number: __________________ Quote Date: ______________

Policyholder Information

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Marital Status:
Nationality:	Passport Number:	
French Social Security #:	Occupation:	Employer:

Do you currently have health coverage with any other insurer? If yes, which insurer? ○ Yes ○ No

* The coverage start date will commence on the 1st or 15th day of the month. The commencement month will vary depending on the method of payment and date. Please refer to the Payment Authorization section on page 7.

Contact Information

Phone *(Main)*:	Phone *(Work)*:
Email:	Fax *(Optional)*:

Country of Origin Address – This is the address where you are residing in your country of origin.

Address 1:

Address 2:

Town / City / Locality:	State:	Postal Code:	Country:

Destination Address – This is the address where you are residing abroad.

Address 1:

Address 2:

Town / City / Locality:	State:	Postal Code:	Country:

Dependent Information

Dependent 1

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 2

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 3

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 4

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

If you have additional dependents, please request an Additional Dependents Form.

If any of the above dependents reside at a separate address, please complete the section below.

Dependents

○ Dependent 1 ○ Dependent 2 ○ Dependent 3 ○ Dependent 4

Address 1:			
Address 2:			
Town / City / Locality:	State:	Postal Code:	Country:

Confidential Medical Questionnaire

This section asks for health and medical details, past and present, about yourself and each dependent named. Please choose Yes or No to every question for every person. If you choose Yes to a question, please give full details in the space provided. Please tell us about any known or suspected conditions or symptoms even if professional advice has not yet been sought. You should also include details of any conditions for which you have ever made claims.

	Policyholder		Dependent 1		Dependent 2		Dependent 3		Dependent 4	
How tall are you?										
How much do you weigh?										
Are you a smoker?	◯ Yes	◯ No	◯ Yes	◯ No	◯ Yes	◯ No	◯ Yes	◯ No	◯ Yes	◯ No
	Qty:	Yrs:	Qty:	Yrs:	Qty:	Yrs:	Qty:	Yrs:	Qty:	Yrs:

Are you or your spouse pregnant or in the process of adopting a child? ◯ Yes ◯ No

If "Yes" please provide details about the pregnancy below:

Are complications anticipated with this pregnancy? ◯ Yes ◯ No

If "Yes", please provide details about the anticipated complications with the pregnancy:

Have you, or your dependents ever been insured for a pre-existing or chronic condition (requiring regular medical care)? ◯ Yes ◯ No

Have you or your dependents ever seen a doctor or other healthcare professional and/or been admitted to a hospital, had an operation/ procedure, or had an investigation (e.g. a scan/blood tests) for any of the medical conditions listed in questions 1–14 below?

1.	Heart or circulatory disorders e.g., high blood pressure, stroke, palpitations, blood clots, high cholesterol or triglycerides, angina / chest pains, heart attack, heart failure, abnormal heart beat, aneurysms, or varicose veins	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
2.	Endocrine (glandular) disorders e.g., diabetes (Type 1 or Type 2), thyroid problems, pituitary, adrenal, obesity or other endocrinal conditions	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
3.	Breathing, lung or respiratory disorders e.g., shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or allergies (including hay fever and anaphylaxis)	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
4.	Stomach, intestines, liver or gall bladder disorders e.g., ulcers/inflammation of the stomach or duodenum, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, hemorrhoids/ piles, pancreatitis, liver inflammation, hepatitis, cirrhosis, esophagitis or hernias	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
5.	Cancer, tumors or growths e.g., cysts, polyps, benign growths, enlarged lymph nodes, any cancers or pre- cancerous condition	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
6.	Skin problems e.g., eczema, dermatitis, rashes, psoriasis, acne, cysts, moles that itch or bleed or allergic reactions	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details

Confidential Medical Questionnaire

Question	Answer	Details
7. Brain or nervous system disorders e.g., dementia, migraine, repeated headaches, multiple sclerosis, epilepsy, seizures, paralysis, nerve pain (including sciatica and shingles) or meningitis	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
8. Muscular or skeletal disorders e.g., arthritis, rheumatism, disorders of the knees, neck/shoulders, spinal column problems or any other joint, muscle or bone disorders, cartilage and ligament problems, fractures, osteoporosis, gout or inflammatory conditions	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
9. Reproductive or genital disorders e.g., breast, ovaries, or uterus disorders, endometriosis, history of pregnancy / childbirth complications/ problems (including cesarean sections), eclampsia, premature births, heavy or irregular periods, fibroids, infertility treatments, abnormal smears, polycystic ovaries, testicular or prostate disorders, elevated PSA or sexually transmitted diseases	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
10. Urinary system disorders e.g., kidney or bladder problems (including kidney failure), recurrent urinary infections, incontinence or kidney stones	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
11. Blood/infective/immune disorders e.g., abnormal blood tests, anemia, hemophilia, hepatitis, HIV, lupus, malaria or any autoimmune disorder	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
12. Eye, ear, nose, throat and dental disorders e.g., cataracts, glaucoma, visual impairment, deafness, ear infections, tonsillitis, dental infections, wisdom teeth problems or gingivitis, deviated septum, sinusitis, polyps or other disorders of the nose	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
13. Psychiatric / psychological disorders e.g., schizophrenia, compulsive or eating disorders, depression, stress, anxiety, psychosis, neurosis or need for psychotherapy	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
14. Treatment for drug or alcohol use or dependency.	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details

Confidential Medical Questionnaire

Please also answer the following questions:

Question	Answer	Details
1. Is anyone taking any medication, prescribed or otherwise?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
2. Is anyone receiving any treatment of any kind or expect to require treatment for any current or past health matter or awaiting results of any tests?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
3. Has anyone experienced any signs or symptoms of any health matter not disclosed in the prior questions (regardless if a health care professional has been consulted)?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
4. Does anyone have any birth defects or congenital abnormalities, developmental delay, autism, down syndrome or heart / lung /kidney malformation?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and details
5. Is anyone a candidate for, or recipient of, an organ, bone marrow or stem cell transplant?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and details
6. Has anyone ever had any signs or symptoms or an examination, treatment, procedure, hospitalization, surgery and/ or intervention due to other medical conditions not disclosed in the prior questions or due to any other reason?	◯ Yes ◯ No	If "Yes", please provide name(s) and details
7. Has anyone engaged, or intend to engage, in any sport, profession or hobby that could be potentially hazardous or do you engage in any professional sport?	◯ Yes ◯ No	If "Yes", please provide name(s) and details
8. Has anyone gained or lost more than 12 kilos or 25 pounds in the last 12 months?	◯ Yes ◯ No	If "Yes", please provide name(s) and details
9. Has anyone been declined, postponed, surcharged or limited for health or accident insurance?	◯ Yes ◯ No	If "Yes", please provide name(s) and details

NOTE: Any and all diagnoses, treatments, signs or symptoms must be disclosed for applicant and dependent(s) in relation to all questions in the Confidential Medical Questionnaire.

Primary Care Physician

Physician's Name:			Phone:
Address 1:			
Address 2:			
Town / City / Locality:	State:	Postal Code:	Country:

Select a Coverage Zone

- ○ **Zone 1** Worldwide (including USA)
- ○ **Zone 2** Worldwide (excluding Bahamas, Bermuda, Brazil, Canada, China, Hong Kong, Japan, Panama, Singapore, Switzerland, United Kingdom and United States)

Select a Plan

- ○ **ORBE Gold**
- ○ **ORBE Platinum**

Choose your deductible

○ **$0** ○ **$500** ○ **$1,000** ○ **$2,000** ○ **$5,000**

FRENCH NATIONALS ONLY – Do you have supplemental coverage with the CFE?

○ **Yes** ○ **No**

Select Additional Benefits (Optional)

Eligibility: Individuals over the age of 18 years, plus their eligible dependents. Maximum entry age is 70 years. Optional benefits (dental and vision) are only available as an add on to your policy at the time of application.

Maternity Coverage:

WellAway provides a maternity option for the policyholder or spouse (age 18 and over). If you or your spouse is pregnant at the time of enrollment or following the effective date of coverage, the maternity option will have a 10 month waiting period. The maternity rider covers maternity and well baby services.

○ **Yes**, I would like to add maternity coverage to my policy.

Dental and Vision Package:

Dental coverage is only available as an add on to your policy. As an optional benefit, we offer dental coverage with a maximum annual limit of $3,500 per person per benefit period. The benefits include preventive, basic, major and orthodontic treatment. The orthodontic treatment is available to dependent children under the age of 18, with a lifetime limit of $1,200 USD.

It is important to look after your eyes. Our vision benefits cover you and your dependents for routine vision exams, eye glass frames, and contact lenses. Please refer to the schedule of benefits for complete plan highlights. Vision option is not available without dental coverage.

Dental and Vision Package for coverage in the U.S. only

○ **Yes**, I would like to add dental and vision coverage in the U.S. to my policy.

Dental and Vision Package, Worldwide coverage, including the U.S.

○ **Yes**, I would like to add Worldwide dental and vision coverage to my policy.

NOTE: By selecting a benefits option above, all members of the family will be covered.

Payment Authorization

Premium

Select frequency of direct debits:

◯ **Monthly** ◯ **Quarterly** ◯ **Semi-annually** ◯ **Annual**

Who is paying for the Policy? ◯ **Individual** ◯ **Company** **Company Name** ____________________

First Name:	Last Name:		
Address 1:			
Address 2:			
Town / City / Locality:	State:	Postal Code:	Country:
Email:		Telephone Number:	

NOTE: Policyholder is solely responsible for the payment of all premiums. Failure to pay your premium (including if your premium is paid by a third party) will result in cancellation of your policy, in accordance with the terms of conditions of your policy. In the event your policy is terminated for non-payment of your premium, you may be able to reinstate your policy, subject to the policy terms and conditions and underwriting approval.

Payment Method

◯ **Credit Card**

◯ **Debit Card**

◯ **Visa** ◯ **MasterCard** ◯ **Discover Card** ◯ **American Express**

I authorize WellAway Limited to charge my credit/debit card for the premium payment.

Name on Card	Card Number
Expiration Date *(mm/yy)*	CCV
Authorized Signature	Date Signed *(mm/dd/yyyy)*

WellAway Limited does not charge its client transaction fees; any fees charged to you are from your credit card company. Please note that your bank may charge you foreign transaction fees. A credit card with no foreign transaction fees must be used to avoid bank fees charged by your credit card company. Please notify your bank to avoid payment rejection.

Acknowledgments and Authorizations

Please review your application for completeness and accuracy and read the section below carefully before signing.

I confirm that the answers and statements contained herein are true, complete, and accurate. I understand and agree to the following:

1. This application and the initial payment do not give me immediate coverage.
2. The coverage will begin once my application has been approved and on the 1st or 15th day of the applicable month.
3. I acknowledge that coverage is contingent upon the complete and accurate disclosure of the information requested on this application.
4. Any changes that occur to an applicant's medical history prior to issue of the policy must be immediately reported to the insurer.
5. This completed application, and any riders will be a part of any policy, if issued.
6. The broker may only submit the application and initial payment on my behalf, and may not promise me coverage, modify WellAway Limited's (WellAway) underwriting policy or terms of coverage, or change or waive any right or requirement.
7. I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding myself and all listed dependents.
8. If WellAway rejects this application, under no circumstances will any benefits be payable.
9. If coverage is rescinded, WellAway will return any premium paid and will not cover any claims.
10. I agree to the ORBE policy 12 month commitment per policy year. I further agree that I may only cancel my policy on its anniversary date. However, if I have a change of circumstances, I will contact WellAway as soon as possible. If I choose to stop paying my Premium, I acknowledge that WellAway will have the right to collect the full Premium amount due for the entire policy year and I authorize WellAway to charge my credit/debit card for any unpaid premium amounts due.
11. I understand and agree that misrepresentations, intentionally fraudulent or incorrect statements, omissions, concealment of facts, or incomplete information on this application may result in voidance of coverage, denial of benefits, claim denial and/or termination of coverage.
12. I acknowledge that each application is medically underwritten and subject to approval by WellAway. I understand that coverage may become effective only after this signed application has been: (i) accepted by WellAway; (ii) accepted by WellAway with a temporary exclusion; or (iii) accepted by WellAway with a permanent exclusion. I further understand WellAway reserves the right not to approve my application and if it does not, I will be notified in writing and if any premium has been paid, it will be returned.

Authorization to Obtain and Disclose Non-medical Information

I authorize WellAway to obtain information that it needs to verify my application for insurance from any government agencies, medical related facilities, medical professionals, hospitals, clinics, or other person or entity, including copies of records, concerning advice, care or treatment provided to me, or dependents, and including any information related to mental illness or the use of drugs or alcohol. I authorize WellAway to share this information with any of its representatives or partners involved in providing the services and coverage agreed upon. I further authorize any insurance company to provide information about prior insurance coverage for my family or me. This authorization shall remain valid until the termination of coverage.

I (we) understand a photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to WellAway.

I (we) may request revocation of this authorization by writing to WellAway. WellAway may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization.

I declare that I am not, nor will be engaged in business with any country, person or activity listed by the U.S. Treasury's Office of Foreign Assets Control (OFAC) or subject to any other sanction, prohibition or restriction under United Nations resolutions or any trade or economic sanctions, laws or regulations of the European Union, United Kingdom, or the United States.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

Policyholder Signature	Date Signed *(mm/dd/yyyy)*

By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual handwritten signature.

If completing application with a broker

Broker Statement

I attest that any assertions made to the client regarding the WellAway products are in accordance with the policy terms and conditions, summary of benefits and other marketing materials provided by WellAway.

Agent/Broker # ___________ Agent/Broker Name:____________________________Company Name:_____________________

Agent/Broker Signature X____ Date: *(mm/dd/yyyy)* ___________________

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Additional Dependents Information

If you have additional dependents, please provide such information below.

Dependent 5

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 6

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 7

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 8

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 9

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		

Dependent 10

Title: ○ Mr. ○ Mrs. ○ Ms.

First Name:	Middle Name:	Last Name:
Sex: ○ Male ○ Female	Date of Birth:	Passport Number:
E-mail (If dependent is over the age of 18):		