

# New American Application

\*Requested coverage start date: \_\_\_\_\_ Quote Number: \_\_\_\_\_ Quote Date: \_\_\_\_\_

## Policyholder Information

Title:  Mr.  Mrs.  Ms.

First Name:	Middle Name:	Last Name:
Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Marital Status:
Nationality:	Passport Number:	
U.S. Visa type:	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 first 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 5.

## Contact Information

### Country of Origin (address before expatriation)

Address 1:

Address 2:

Town / City / Locality:	State:	Postal Code:	Country:
Daytime number (including country code):		Mobile number (include country code):	
Email:			

### Destination (where you will live as an expatriate)

Address 1:

Address 2:

Town / City / Locality:	State:	Postal Code:	Country:
Daytime number (including country code):		Mobile number (include country code):	
Email:			

# Dependent Information

## Dependent 1

Title:  Mr.  Mrs.  Ms.

First Name:	Middle Name:	Last Name:
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Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Passport Number:
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E-mail (If dependent is over the age of 18):

## Dependent 2

Title:  Mr.  Mrs.  Ms.

First Name:	Middle Name:	Last Name:
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Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Passport Number:
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E-mail (If dependent is over the age of 18):

## Dependent 3

Title:  Mr.  Mrs.  Ms.

First Name:	Middle Name:	Last Name:
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Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Passport Number:
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E-mail (If dependent is over the age of 18):

## Dependent 4

Title:  Mr.  Mrs.  Ms.

First Name:	Middle Name:	Last Name:
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Sex: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Passport Number:
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E-mail (If dependent is over the age of 18):

If you have additional dependents, please provide such information on the Additional Dependents information section attached at the end of this application.

If any of the above dependents reside at a separate address in your country of origin, 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:
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# Health Information

In order to better serve our members, WellAway Limited has developed a Case Management Program designed to provide individuals with assistance in making good decisions about their health care and treatment. Through this program, individuals have access to quality medical services in a complex healthcare system.

	Policyholder		Dependent 1		Dependent 2		Dependent 3		Dependent 4	
How tall are you?										
How much do you weigh?										
Are you a smoker?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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, your spouse, or your dependents.....

1. Seen a doctor or other healthcare professional for anything other than a routine check-up in the last 3 years?	<input type="radio"/> Yes <input type="radio"/> No	If "Yes", please provide name(s), date(s) and treatment details	
2. Been admitted to a hospital, had an operation or procedure in the last 7 years?	<input type="radio"/> Yes <input type="radio"/> No	If "Yes", please provide name(s), date(s) and treatment details	
3. Taken any medication, prescribed or otherwise?	<input type="radio"/> Yes <input type="radio"/> No	If "Yes", please provide name(s), date(s) and treatment details	
4. Received treatment of any kind, or expect to require treatment for any current or past medical conditions?	<input type="radio"/> Yes <input type="radio"/> No	If "Yes", please provide name(s), date(s) and treatment details	
5. Experienced any signs or symptoms of any medical problems in the last 2 years, regardless of whether a health care professional has been consulted?	<input type="radio"/> Yes <input type="radio"/> No	If "Yes", please provide name(s), date(s) and treatment details	
6. Do you or your dependents have any of the following health conditions:	<input type="radio"/> Bipolar Disorder <input type="radio"/> AIDS/HIV <input type="radio"/> Cancer <input type="radio"/> Cirrhosis <input type="radio"/> Depression Requiring Hospitalization <input type="radio"/> Diabetes Type I <input type="radio"/> Erythematous	<input type="radio"/> Heart Disease <input type="radio"/> Kidney/Renal Failure <input type="radio"/> Muscular Dystrophy <input type="radio"/> Schizophrenia <input type="radio"/> Systemic Lupus <input type="radio"/> Transplant History <input type="radio"/> Gynecological Disorder	If "Yes", please provide name(s), date(s) and treatment details

**NOTE:** Any and all diagnoses, treatments, signs or symptoms must be disclosed for all members including dependents in relation to all Case Management Program questions. Any incomplete information may delay the approval of your application.

## Primary Care Physician

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

## Select a Plan

- Premier Freedom 3500
- Premier Freedom 4500
- Prestige Freedom 1500
- Prestige Freedom 2500
- Elite Freedom 1000

## Dental and Vision Package (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.

### About the 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

**NOTE:** The coverage start date for a premium payment received via wire after the 20th day of the month or via credit/debit card after the 25th day of the month will begin the second consecutive month after the payment date (for example, if payment is received January 26, coverage will begin March 1st).

Select frequency of direct debits:

- Monthly     Quarterly     Semi-Annual\*     Annual\*

*\*Elite Freedom Plan policyholders must make semi-annual payments.*

**If payor is not the applicant, please provide:**

First Name:

Last Name:

Address 1:

Address 2:

Town / City / Locality:

State:

Postal Code:

Country:

Payor's Email Address:

**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

- 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 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.

## 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)
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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: <input type="radio"/> Male <input type="radio"/> 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: <input type="radio"/> Male <input type="radio"/> 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: <input type="radio"/> Male <input type="radio"/> 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: <input type="radio"/> Male <input type="radio"/> 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: <input type="radio"/> Male <input type="radio"/> 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: <input type="radio"/> Male <input type="radio"/> Female	Date of Birth:	Passport Number:

E-mail (If dependent is over the age of 18):