WellAway
Keeping You Well, While You're Away.®

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La Vie À L'Étranger 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 #:
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

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. (USA address only)

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 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:

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?	◯ 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, 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?	◯ Yes ◯ 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?	◯ Yes ◯ No	If "Yes", please provide name(s), date(s) and treatment details
3.	Taken any medication, prescribed or otherwise?	◯ Yes ◯ 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?	◯ Yes ◯ 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?	◯ Yes ◯ 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:	◯ Bipolar Disorder ◯ AIDS/HIV ◯ Cancer ◯ Cirrhosis ◯ Depression Requiring Hospitalization ◯ Diabetes Type I ◯ Erythematous	◯ Heart Disease ◯ Kidney/Renal Failure ◯ Muscular Dystrophy ◯ Schizophrenia ◯ Systemic Lupus ◯ Transplant History ◯ 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 4500**

◯ **Prestige 2500**

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**

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.

Agreement

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

Statement of Understanding

I personally completed this application and 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 paid on the first 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. I represent that all information provided in this application is accurate and complete.
5. This completed application, and any supplements or amendments 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 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 Limited rejects this application, under no circumstances will any benefits be payable.
9. Receipt of money, or charging my credit card by WellAway Limited does not constitute approval of my application or create coverage.
10. The policy requires some medical services to be authorized by WellAway Limited or its representative before the services are provided, and benefits for these services may be reduced if the prior authorization is not obtained.
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 Limited to obtain information that it needs to verify my application for insurance. I authorize WellAway to share this information with any of its representatives or partners involved in providing the services and coverage agreed upon. Any employer, insurance company, government agency, or consumer-reporting agency having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to WellAway Limited. 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 Limited.

I (we) may request revocation of this authorization by writing to WellAway. WellAway Limited 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) http://www.ustreas.gov/offices/enforcement/ofac/ or any other similar office or organization.

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)*

If completing application with a broker

Broker Statement

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

Agent/Broker # _____ Agent/Broker Name:_____Company Name:_____

Agent/Broker Signature X_____ Date: *(mm/dd/yyyy)* _____

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):		