Enrollment Application

La Vie À L'Étranger

WellAway®

Sécurité Sociale
Caisse des Français
de l'Étranger

You are applying for enrollment to our program in conjunction with the CFE. Please complete the separate CFE application and send it to us at info@wellaway.com

Bermuda: +1 441 296 0651
Skype: +1 888 983 2370

info@wellaway.com
www.wellaway.com

WellAway Limited
Canon's Court, 22 Victoria St.
PO Box HM1179
Hamilton HM EX, Bermuda

Rev.01302018

Policyholder Information

Coverage start date* *(mm/yyyy)*	**Quote number**	**Quote date** *(mm/dd/yyyy)*
First name	**Middle name**	**Last name**
Nationality	**Date of birth** *(mm/dd/yyyy)*	**Sex** ☐ **Female** ☐ **Male**

Passport number	**U.S. visa type**	**Marital status**
Occupation	**Employer**	

Do you currently have health coverage with another insurer? ☐ **Yes** ☐ **No**

If yes, which insurer?

Insurance company	**Policy number**

* 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 4.

Contact Information

Main phone number	**Work phone number**	**Fax number** (optional)
Email address		
Origin address line 1		
Origin address line 2		
City/town/locality	**Postal code**	**Country**
Destination address line 1 *(USA address only)*		
Destination address line 2 *(USA address only)*		
City *(USA only)*	**State** *(USA only)*	**Zip Code** *(USA only)*

Physician Information

Your physician's name	**Phone number**
Address	

Dependent Information

DEPENDENT 1

First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	**Passport number**	**Sex** ☐ **Female** ☐ **Male**
Email address *(if dependent is over the age of 18)*		

DEPENDENT 2

First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	**Passport number**	**Sex** ☐ **Female** ☐ **Male**
Email address *(if dependent is over the age of 18)*		

DEPENDENT 3

First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	**Passport number**	**Sex** ☐ **Female** ☐ **Male**
Email address *(if dependent is over the age of 18)*		

DEPENDENT 4

First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	**Passport number**	**Sex** ☐ **Female** ☐ **Male**
Email address *(if dependent is over the age of 18)*		

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

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

☐ **Dependent 1** ☐ **Dependent 2** ☐ **Dependent 3** ☐ **Dependent 4**

Dependent address line 1		
Dependent address line 2		**City/town/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.

How tall are you?

Policyholder	Dependent 1	Dependent 2	Dependent 3	Dependent 4

How much do you weigh?

Policyholder	Dependent 1	Dependent 2	Dependent 3	Dependent 4

Are you, or any of your dependents, a tobacco user?	○ Yes	○ No	**If yes, provide name(s)**
Are you or your spouse pregnant or in the process of adopting a child?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**
Have you or any of your dependents... Seen a doctor or other healthcare professional other than a routine check-up in the last 3 years?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**
Been admitted to a hospital, had an operation or procedure in the last 7 years?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**
Take any medication, prescribed or otherwise?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**
Received treatment of any kind, or expect to require treatment for any current or past health matter?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**
Experienced any signs/symptoms of any health matter in the last 2 years (regardless if a healthcare professional has been consulted)?	○ Yes	○ No	**If yes, provide name(s), date(s) and treatment details**

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**

If yes, 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.

Select a Plan

- ○ **Premier 4500**
- ○ **Prestige 2500**

Select Additional Benefits **(Optional)**

Eligibility: Individuals over the age of 19 years, plus their eligible dependents. Maximum entry age is 64 years. Optional Benefits (Dental and Vision) are only available as an add on to your Policy.

DENTAL COVERAGE

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 19, with a lifetime limit of $1,200 USD.

- ○ **Policyholder Only**
- ○ **Policyholder and Spouse**
- ○ **Policyholder and Child**
- ○ **Policyholder and Family***

NOTE: Children under 19 years of age have limited vision and dental benefits under an ACA plan.

DENTAL AND VISION COVERAGE

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.

- ○ **Policyholder Only**
- ○ **Policyholder and Spouse**
- ○ **Policyholder and Child**
- ○ **Policyholder and Family***

NOTE: The same members selected in the dental option will be covered by the vision option.

** Policyholder and Family constitutes coverage for Policyholder, Spouse and one or more Children.*

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 Jan 26, coverage will begin March 1).

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:			

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.

Select 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. My WellAway coverage start date must be 3 or more days from the application enrollment date.
3. The coverage will begin once your application has been approved and your first premium has been paid.
4. I acknowledge that coverage is contingent upon the complete and accurate disclosure of the information requested on this application.
5. I represent that all information provided in this application is accurate and complete.
6. This completed application, and any supplements or amendments will be a part of any policy, if issued.
7. 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.
8. 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.
9. If WellAway Limited rejects this application, under no circumstances will any benefits be payable.
10. Receipt of money, or charging my credit card by WellAway Limited does not constitute approval of my application or create coverage.
11. 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.
12. 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 Nonmedical 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)

BROKER STATEMENT

I attest that any assertions made to the client regarding WellAway products are in accordance with the Policy Terms and Conditions, Schedule of Benefits and other marketing materials provided by WellAway Limited.

Agent/broker number	Agent/broker Name	Company name

Agent/broker signature	Date signed (mm/dd/yyyy)

Additional Dependents Information

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

WellAway®

DEPENDENT 5

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Passport number	Sex
		☐ Female ☐ Male

Email address *(if dependent is over the age of 18)*

DEPENDENT 6

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Passport number	Sex
		☐ Female ☐ Male

Email address *(if dependent is over the age of 18)*

DEPENDENT 7

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Passport number	Sex
		☐ Female ☐ Male

Email address *(if dependent is over the age of 18)*

DEPENDENT 8

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Passport number	Sex
		☐ Female ☐ Male

Email address *(if dependent is over the age of 18)*

DEPENDENT 9

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Passport number	Sex
		☐ Female ☐ Male

Email address *(if dependent is over the age of 18)*