



WellAway®

NEW AMERICAN

Enrollment Application

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



WellAway®

Policyholder Information

New American Application

*Requested coverage start date: / /		Quote Number:			Quote Date:		
Title:	Mr.	Mrs.	Ms.				
First Name:			Middle Name:			Last Name:	
Sex:	Male	Female	Nationality:			Date of Birth:	
Passport Number:			Marital Status:				
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):		

Permanent 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:				

Dependent Information

Dependents

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:	

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
	Quantity	Years	Quantity	Years	Quantity	Years	Quantity	Years	Quantity	Years

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

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:	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Heart Disease <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Kidney/Renal Failure <input type="checkbox"/> Cancer <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Depression Requiring Hospitalization <input type="checkbox"/> Systemic Lupus <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Transplant History <input type="checkbox"/> Erythematous <input type="checkbox"/> 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.

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

Select a Plan

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

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.

You can choose between two options of coverage: dental or dental and vision.

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 18, with a lifetime limit of \$1,200 USD.

Yes, I would like to add dental coverage to my policy.

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.

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

Note: By selecting an option above, all members of the family will be covered.

Payment Authorization

New American Application

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:							

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

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.

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: ___/___/_____

The contents of this material are the exclusive intellectual property of WellAway Limited. No reproduction, changes or copying is possible without the consent of WellAway Limited. The WellAway brand and WellAway logos are the registered marks of WellAway Limited and WellAway SA, Hamilton, Bermuda.

Additional Dependents Information

New American Application

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):					