



Individual Health Insurance Application

For company use
Policy number

The Insurer retains the right to contact the applicant if any question is not explained in detail or if additional information is required.

New policy Additional dependents Change of plan

1 PERSONAL INFORMATION

Name of applicants (Policyholder/dependents)	Relationship to Policyholder	Marital status*	Date of birth Month/Day/Year	Sex	Weight	Height
First name: _____ M.I. _____ Last name: _____	Policyholder		MM / DD / YYYY	M <input type="radio"/> F <input type="radio"/>	_____ <input type="radio"/> lbs <input type="radio"/> kg	_____ <input type="radio"/> ft <input type="radio"/> m
First name: _____ M.I. _____ Last name: _____			MM / DD / YYYY	M <input type="radio"/> F <input type="radio"/>	_____ <input type="radio"/> lbs <input type="radio"/> kg	_____ <input type="radio"/> ft <input type="radio"/> m
First name: _____ M.I. _____ Last name: _____			MM / DD / YYYY	M <input type="radio"/> F <input type="radio"/>	_____ <input type="radio"/> lbs <input type="radio"/> kg	_____ <input type="radio"/> ft <input type="radio"/> m
First name: _____ M.I. _____ Last name: _____			MM / DD / YYYY	M <input type="radio"/> F <input type="radio"/>	_____ <input type="radio"/> lbs <input type="radio"/> kg	_____ <input type="radio"/> ft <input type="radio"/> m

If this Application includes children **19 years of age or older**, are any of them a full-time student in a college or university? Yes No

If "Yes", please indicate the name of the college or university: _____

If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm.

*S—single M—married DP—domestic partner D—divorced W—widow **Note:** An Attending Physician Statement (APS) is required for any person **age 65 and older**.

2 PRODUCT, PLAN AND ADDITIONAL COVERAGE REQUESTED

Please select product: Bupa Critical Care Bupa Essential Care Bupa Secure Care Bupa Advantage Care: Worldwide Latin America Only*

Please select plan: 1 2 3 4 5 6 Other _____

Amedex Renewals/Additions: Worldwide Select Prestige Choice Deductible value: _____ / _____ / _____

Requested Effective Date of Coverage: MM / DD / YYYY Additional coverage: Maternity complications Transplant procedures

Other _____

*Excludes Mexico

3 PREVIOUS INSURANCE INFORMATION

(3.1) Will the requested coverage replace any existing insurance? Yes No

If "Yes", please attach copy of certificate of coverage and receipt of last payment.

Company Name: _____

Product Name: _____

Deductible Value: _____ Policy No.: _____

3 PREVIOUS INSURANCE INFORMATION (continued)

(3.2) Has any previous application for health or life insurance been declined, accepted subject to restrictions, or at a premium higher than the standard rates of the insurer for any of the applicants?Yes No

If "Yes", please explain: _____

4 GENERAL INFORMATION

(4.1) Address

Home	_____		
Zip code:	_____	City/State:	_____
		Country of residence:	_____
Mailing (if different from above)	_____		
Zip code:	_____	City/State:	_____
		Country:	_____

(4.2) Residence/Citizenship Status

Are you a U.S. Citizen or permanent resident of the United States of America? Yes No

If the answer is "Yes", have you legally resided in the United States of America for more than 6 months in any one year period? Yes No

(4.3) Telephones, fax and e-mail

Home	Country code	Area code	Number	Work	Country code	Area code	Number
	_____	_____	_____		_____	_____	_____
Fax	Country code	Area code	Number	E-mail	_____		
	_____	_____	_____		_____		

5 BENEFICIARY INFORMATION

Names of beneficiaries			Relationship to Policyholder
First name:	_____	M.I.	_____
Last name:	_____		
First name:	_____	M.I.	_____
Last name:	_____		

6 MEDICAL INFORMATION

(6.1) Family doctor(s)

Applicant	Doctor's name	Specialty	Telephone

(6.2) Medical check-ups

Has any applicant had any pediatric, gynecological, or routine examination in the past five years?.....Yes No If "Yes", please explain below.

Applicant	Type of exam	Date	Result:	If abnormal, please describe.
		MM / DD / YYYY	Normal <input type="radio"/> Abnormal <input type="radio"/>	
		MM / DD / YYYY	Normal <input type="radio"/> Abnormal <input type="radio"/>	
		MM / DD / YYYY	Normal <input type="radio"/> Abnormal <input type="radio"/>	
		MM / DD / YYYY	Normal <input type="radio"/> Abnormal <input type="radio"/>	

If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm.

(6.3) Medical conditions

Has any applicant ever had...		Yes	No
a	infections?	<input type="radio"/>	<input type="radio"/>
b	vision, ear or hearing, nose or throat disorders?	<input type="radio"/>	<input type="radio"/>
c	seizures, migraine, paralysis or other neurological disorders?	<input type="radio"/>	<input type="radio"/>
d	heart disorders, circulatory disorders, high blood pressure, high cholesterol or high triglycerides?	<input type="radio"/>	<input type="radio"/>
e	allergies, asthma, bronchitis or other pulmonary disorders?	<input type="radio"/>	<input type="radio"/>
f	esophagus, stomach, intestines or pancreas diseases, hepatitis, other liver diseases or other digestive disorders?	<input type="radio"/>	<input type="radio"/>
g	kidney or urinary tract diseases?	<input type="radio"/>	<input type="radio"/>
h	spinal column problems, rheumatism, arthritis, gout, or other muscle, joint or bone disorders?	<input type="radio"/>	<input type="radio"/>
i	cancer or benign tumors?	<input type="radio"/>	<input type="radio"/>
j	anemia, leukemia/lymphoma or other blood disorders?	<input type="radio"/>	<input type="radio"/>
k	diabetes, thyroid gland disorders or other endocrine/hormonal disorders?	<input type="radio"/>	<input type="radio"/>
l	prostate disorders?	<input type="radio"/>	<input type="radio"/>
m	sexually transmitted or sexual organs diseases, or other reproductive disorders?	<input type="radio"/>	<input type="radio"/>
n	breast, ovaries/uterus disorders, or other gynecological disorders?	<input type="radio"/>	<input type="radio"/>
o	skin disorders?	<input type="radio"/>	<input type="radio"/>
p	congenital or hereditary disorders?	<input type="radio"/>	<input type="radio"/>
q	any other disease, disorder, illness, injury, accident, surgery, pending surgery or hospitalization not mentioned above?	<input type="radio"/>	<input type="radio"/>

If you have responded "Yes" to any of the above, please explain on the following page.

6 MEDICAL INFORMATION (continued)

(6.4) Medical condition(s) / Explanation(s)

Question □	Applicant: □□□□□□□□□□□□□□□□	Condition: □□□□□□□□□□□□□□□□	From: □□/□□/□□□□ MM DD YYYY	To: □□/□□/□□□□ MM DD YYYY
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If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm.

(6.5) Medication(s)

Is any applicant currently taking medication, or been advised at any time to take any medication? Yes No If "Yes", please explain below.

Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: □□/□□/□□□□ MM DD YYYY	To: □□/□□/□□□□ MM DD YYYY
Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: □□/□□/□□□□ MM DD YYYY	To: □□/□□/□□□□ MM DD YYYY
Applicant: □□□□□□□□□□□□□□□□	Name of medication: □□□□□□□□□□□□□□□□	Reason: □□□□□□□□□□□□□□□□	Amount: □□□□□□□□□□□□□□□□	Frequency: □□□□□□□□□□□□□□□□	From: □□/□□/□□□□ MM DD YYYY	To: □□/□□/□□□□ MM DD YYYY
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If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm.

(6.6) Habit(s)

Has any applicant ever smoked cigarettes, consumed nicotine products, alcohol or illegal drugs? Yes No
If "Yes", please explain below.

Applicant: □□□□□□□□□□□□□□□□	Type: □□□□□□□□□□□□□□□□	Amount per day □□□□□□□□□□□□□□□□
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6 MEDICAL INFORMATION (continued)

(6.7) Family history

Does any applicant have a family history of diabetes, hypertension, cancer, or a congenital or hereditary cardiovascular disorder?Yes No If "Yes", please explain below.

Applicant	Relative with the disorder (please check)				Disorder
	Father	Mother	Sibling	Child	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7 ACKNOWLEDGEMENT AND AUTHORIZATION

I certify that I have read and reviewed all the answers and statements declared in this Application, and that to the best of my ability, they are complete and truthful. I understand that any omissions, incorrect or incomplete statements could cause claims to be denied, and the policy to be modified, cancelled or rescinded. If any person requires medical care or treatment after the Application for insurance is signed, but before the effective date of this policy, I will then provide full details to the Insurer for final approval before coverage is effective. I agree to accept the Policy with the terms and conditions as issued. Otherwise, I will notify my disagreement to the Insurer in writing, within the first ten (10) days of receipt of the insurance policy. In the event that I am represented by a Producer, I hereby authorize that person to receive my Policy Conditions, Certificate of Coverage, and all documents related to my coverage.

8 AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person having any records or knowledge of myself or my health, including any member of my family, to give any such information to Bupa Insurance Company, USA Medical Services and their affiliates. A copy of this Authorization shall be as valid as the original. This Authorization shall remain valid as long as any insurance is in effect.

9 SIGNATURE: My signature below constitutes acceptance of all items listed above.

Applicant's Signature: <input checked="" type="checkbox"/>	Applicant's printed name: <input type="text"/>	Date: <input type="text"/>
Spouse's Signature: <input checked="" type="checkbox"/>	Spouse's printed name: <input type="text"/>	Date: <input type="text"/>

As Producer, I accept full responsibility for the submission of this Application, sending all the collected premiums, and for the delivery of the Policy when issued.

I do not know of any condition that has not been disclosed in this Application which will affect the insurability of the proposed insureds.

Producer's Signature (witness): <input checked="" type="checkbox"/>	Producer's printed name: Caribbean Hotel and Tourism Association	Producer's Code: 8102
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10 PAYMENT INFORMATION (payment must be submitted with the Application)

Policy type: Annual Semi-Annual Quarterly

Premium: US \$ _____
Optional health rider(s): US \$ _____
Annual administrative fee: US \$ 75.00
Total amount: US \$ _____

Payment Method: Option 1

Cashier's check Check Money order Traveler's check

Note: **DO NOT SEND CASH.** Payment must be made to: Bupa Worldwide Corporation

Payment Method: Option 2

Wire transfer Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 063000021, Swift Number: PNBPU33

Payment Method: Option 3

ACH Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 067006432

Payment Method: Option 4

Credit card Please provide the following information:

I, _____, authorize Bupa Worldwide Corporation

to charge my credit card:    

Credit card number _____ Expiration date _____ Month _____ Year _____ CVC _____

Amount to charge US \$ _____

Identity Card number _____ (For Venezuelan residents only)

Cardholder's billing address (where the credit card statement is received)

Cardholder's phone number _____

Cardholder's Signature _____

AUTOMATIC DEBIT FOR FUTURE RENEWALS Yes No

My signature on this document hereby authorizes Bupa Worldwide Corporation (hereinafter "Bupa") to debit the credit card and/or bank account directly, as indicated above, and pay the insurance premiums of my Bupa health insurance Policy.

I understand that if there are any changes to my Bupa insurance Policy, the amount of the approved premium may also change. I further understand that a true and correct copy of this Agreement will be forwarded to my credit card and/or banking institution. In signing this Agreement, I request and instruct the institution to allow Bupa to directly debit my account and pay the health insurance premium, unless I instruct otherwise in writing.

In the event that a direct debit to pay my Bupa health insurance Policy is, for any reason, rejected or declined, I acknowledge that it will be my personal responsibility to immediately pay the premiums of my health insurance Policy, or that my Policy may lapse, be cancelled and/or terminated.

By signing, I authorize automatic deductions for future renewals.

Policyholder's Signature

Cardholder's Signature

____ / ____ / ____
MM DD YYYY
Date

TEMPORARY EMERGENCY COVERAGE

This Temporary Emergency Coverage does not provide any coverage except as specified below and is subject to the fulfillment of all the terms and conditions. It is only valid when the full modal premium selected is included with the Application.

AMOUNT OF TEMPORARY EMERGENCY COVERAGE

From the time the Application and total premium for this Policy are received by the Insurer, Bupa Insurance Company, through the effective date of the Policy, or thirty (30) days from the date said Application is received by the Insurer, whichever date comes first, the Insurer agrees to insure all the proposed Insureds (including spouse and children) for covered medical expenses resulting from accidental bodily injury incurred while this Temporary Emergency Coverage is in effect, up to a maximum benefit of twenty-five thousand dollars (\$25,000) per Policy. This temporary accident coverage is subject to and governed by the respective policy terms, provisions, and exclusions which would have been applicable, had the Policy been in effect on the date of the accident of the proposed Insured.

This benefit is subject to the deductible for the plan chosen by the proposed Insured and does not apply if the Application is declined for any reason or the Policy is rejected by the Insured after it has been issued. The injuries sustained in an accident while the Application is being evaluated cannot be a reason to decline an Application.

CONDITIONS THAT MUST BE MET FOR THE TEMPORARY EMERGENCY COVERAGE TO BE EFFECTIVE

1. Application duly completed.
2. All medical and non-medical requirements and any other information requested by Bupa are received in our offices.
3. The proposed Insured must be insurable according to the Insurer's underwriting guidelines.
4. The premium sent with the Application must equal or exceed the first modal minimum premium and must be in US currency payable to Bupa Worldwide Corporation.
5. Said premium must be good and collectible if paid by check, draft, credit card or money order before the coverage goes into effect.
6. The Policy is not declined by the Insured after it has been issued.

All the statements and answers included in this Application are true, complete and correctly stated to the best of my knowledge and shall be the basis for any policy issued on this Application. Any omissions or incorrect or incomplete statements may result in the denial of a claim, the modification of the contract, or the rescission of the insurance Policy, pursuant to the terms and conditions of the Policy.

All the above conditions must be met in order for the temporary coverage to be in effect. The temporary coverage will terminate when the coverage applied for is effective, denied, or when coverage other than applied for is offered. The temporary coverage is valid for 30 days from the date of receipt of the Application, and premium, and will terminate thereafter.

The Producer, representative, or agent does not have authority to waive or alter any of the conditions, cannot bind Bupa Insurance Company to accept the risk, and cannot change any of the terms of this document. This coverage is not valid until payment made to Bupa Worldwide Corporation is rendered and the funds are deposited. I, therefore, authorize Bupa to charge or deposit my premium payment in order to receive this coverage.

I have read and understood all the conditions contained in this document.

Signature of Applicant

Date (MM/DD/YYYY)

I hereby certify that I received the sum of US\$ _____ as payment for the health insurance of

Applicant's Name

_____ requested on this date.

Producer's Name

Producer's Signature

Date (MM/DD/YYYY)

Please cut along the dotted line

Copy for the Policyholder

AMOUNT OF TEMPORARY EMERGENCY COVERAGE

From the time the Application and total premium for this Policy is received by the Insurer, Bupa Insurance Company, through the effective date of the Policy, or thirty (30) days from the date said Application is received by the Insurer, whichever date comes first, the Insurer agrees to insure all the proposed Insureds (including spouse and children) for covered medical expenses resulting from accidental bodily injury incurred while this Temporary Emergency Coverage is in effect, up to a maximum benefit of twenty-five thousand dollars (\$25,000) per Policy. This temporary accident coverage is subject to and governed by the respective Policy terms, provisions, and exclusions which would have been applicable, had the Policy been in effect on the date of the accident of the proposed Insured.

This benefit is subject to the deductible for the plan chosen by the proposed Insured and does not apply if the Application is declined for any reason or the Policy is rejected by the Insured after it has been issued. The injuries sustained in an accident while the Application is being evaluated cannot be a reason to decline an Application.



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