

BUPA CORPORATE CARE ENROLLMENT FORM FOR CMB CARDHOLDERS



1. APPLICANT'S INFORMATION

Last Name				First Name																	
Place of Birth			Date of Birth	MM/DD/YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female																
Address	Street Address																				
Telephone Number				E-mail address																	
Occupation				Employer																	
<input type="checkbox"/> Approves to charge account in name of:																					
<input type="checkbox"/> Monthly <input type="checkbox"/> Annualy																					
<table border="0"> <tr> <td></td> <td>Monthly</td> <td>Annual</td> </tr> <tr> <td><input type="checkbox"/> Cardholder - Applicant only</td> <td>AWG 131.04</td> <td>AWG 1,572.47</td> </tr> <tr> <td><input type="checkbox"/> Cardholder + Spouse</td> <td>AWG 262.07</td> <td>AWG 3,144.94</td> </tr> <tr> <td><input type="checkbox"/> Cardholder + Child(ren)</td> <td>AWG 262.07</td> <td>AWG 3,144.94</td> </tr> <tr> <td><input type="checkbox"/> Cardholder + Family</td> <td>AWG 393.12</td> <td>AWG 4,717.41</td> </tr> </table>								Monthly	Annual	<input type="checkbox"/> Cardholder - Applicant only	AWG 131.04	AWG 1,572.47	<input type="checkbox"/> Cardholder + Spouse	AWG 262.07	AWG 3,144.94	<input type="checkbox"/> Cardholder + Child(ren)	AWG 262.07	AWG 3,144.94	<input type="checkbox"/> Cardholder + Family	AWG 393.12	AWG 4,717.41
	Monthly	Annual																			
<input type="checkbox"/> Cardholder - Applicant only	AWG 131.04	AWG 1,572.47																			
<input type="checkbox"/> Cardholder + Spouse	AWG 262.07	AWG 3,144.94																			
<input type="checkbox"/> Cardholder + Child(ren)	AWG 262.07	AWG 3,144.94																			
<input type="checkbox"/> Cardholder + Family	AWG 393.12	AWG 4,717.41																			

2. DEPENDENT'S INFORMATION

Last Name				First Name		
Place of Birth			Date of Birth	MM/DD/YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to applicant						
Last Name				First Name		
Place of Birth			Date of Birth	MM/DD/YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to applicant						
Last Name				First Name		
Place of Birth			Date of Birth	MM/DD/YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Relation to applicant						

3. ACKNOWLEDGEMENT

By signing or completing this form, I understand and agree that the benefits and conditions of the medical plan are established in separate documents that Caribbean Mercantile Bank N.V. must provide to each plan Member (See the Table of Benefits, Membership Guide and Terms and Conditions). Bupa Insurance Company (the "Insurance Company") reserves the right to accept or reject my enrollment application. The coverage provided will become effective on inception date of the policy.

Restrictions: New members and/or dependents that currently have or have ever been diagnosed with the following conditions are not able to apply: Active Malignant Tumors and/or Cancer, Autoimmune Disease(s), Chronic Hepatitis, or Muscular Dystrophy.

Waiting Period: A waiting period of twelve (12) months applies to all pre-existing conditions.

It is understood that coverage is effective for twelve (12) months from the first of the month following approval and may be renewed for a similar period upon renegotiation of its terms at least thirty (30) days prior to its termination, provided such coverage is not first cancelled by the Applicant or Group Sponsor.

4. SIGNATURE

Signature of Applicant			Date	MM/DD/YYYY
------------------------	--	--	------	------------

17901 Old Cutler Road, Suite 400 • Palmetto Bay, Florida 33157
Tel. +1 (305) 398-7400 • Fax +1 (305) 275-8484 • www.bupasalud.com/MiBupa