

INTERNATIONAL HEALTHCARE SOLUTIONS INSURANCE APPLICATION

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 product or plan



For company use
Policy number

1. PERSONAL INFORMATION

PLEASE PROVIDE COPY OF IDENTIFICATION DOCUMENT FOR EACH APPLICANT

Name of applicants (policyholder/dependents)		Relationship to policyholder	Marital status ⁽¹⁾	Date of birth		Sex	Weight	Height
First name M.I.		Self		Month/Day/Year		M	<input type="checkbox"/>	<input type="checkbox"/>
Last name						F	<input type="checkbox"/>	<input type="checkbox"/>
Citizenship	Country of birth	ID Type		Number				
First name M.I.				Month/Day/Year		M	<input type="checkbox"/>	<input type="checkbox"/>
Last name						F	<input type="checkbox"/>	<input type="checkbox"/>
ID Type	Number							
First name M.I.				Month/Day/Year		M	<input type="checkbox"/>	<input type="checkbox"/>
Last name						F	<input type="checkbox"/>	<input type="checkbox"/>
ID Type	Number							
First name M.I.				Month/Day/Year		M	<input type="checkbox"/>	<input type="checkbox"/>
Last name						F	<input type="checkbox"/>	<input type="checkbox"/>
ID Type	Number							
First name M.I.				Month/Day/Year		M	<input type="checkbox"/>	<input type="checkbox"/>
Last name						F	<input type="checkbox"/>	<input type="checkbox"/>
ID Type	Number							
<p>If this Application includes children between 19 and 24 years old, are any of them a full-time student in a college or university? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide copy of a certificate or affidavit from the college or university as evidence of full-time student status.</p>								
<p>If requesting coverage for a newborn baby, please answer the following question: Was the baby born as a result of a fertility treatment, was adopted, or born from a surrogate mother? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>If more space is required, please use an additional sheet, signed and dated. If additional sheet is used, please check here to confirm. <input type="checkbox"/></p>								

⁽¹⁾ S - single M - married DP - domestic partner D - divorced W - widow/widower Note: A Treating Physician Statement is required for any person age 65 or older.

2. PRODUCT, PLAN, AND ADDITIONAL COVERAGE REQUESTED

Bupa Supreme Bupa Optimum

Deductible Plan: In or Out-of-country	<input type="checkbox"/> 1 2,000	<input type="checkbox"/> 2 3,500	<input type="checkbox"/> 3 5,000	<input type="checkbox"/> 4 10,000	<input type="checkbox"/> 5 20,000
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Requested effective date of coverage	Month/Day/Year	Additional coverage: If no additional coverage is selected, none will be granted.
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Maternity and Perinatal Complications⁽²⁾

⁽²⁾Please fill out a Maternity Questionnaire

3. OTHER INSURANCE INFORMATION

(3.1) Do you have health insurance coverage with another company? Yes No

Company name			Telephone	
Product name	Deductible value			Policy number
(3.2) Do you intend to keep your insurance coverage with the other company? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(3.3) If the requested coverage is replacing an existing insurance, please attach a copy of the certificate of coverage and receipt of last payment.				
(3.4) 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please explain				

4. GENERAL INFORMATION

(4.1) Residential address

Home				
Zip code		City/State		Country
Mailing (if different from above)				
Zip code		City/State		Country

(4.2) Are all dependents living in the same address indicated above? Yes No If not, please indicate dependent name and address.

Name		Address	
Name		Address	

(4.3) Residence/citizenship status

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

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

(4.4) Telephone, fax and e-mail

Home		Work		Fax	
Cell		Work			

5. BENEFICIARY INFORMATION

Without prejudice to the conditions applicable to the payment of claims contemplated in this policy, in my capacity as policyholder I designate as beneficiary/s the next person/s, who may receive the benefits or payment of claims provided for in this policy in case of my death.

Name	Last name	First name	M.I.	Relationship to policyholder
Name	Last name	First name	M.I.	Relationship to policyholder
Name	Last name	First name	M.I.	Relationship to policyholder

(6.1) Family doctor(s)

Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	

6. MEDICAL INFORMATION (continued)

(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.

Name	Type of exam	Date	Month/Day/Year
Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If abnormal, please describe.			
Name	Type of exam	Date	Month/Day/Year
Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If abnormal, please describe.			
Name	Type of exam	Date	Month/Day/Year
Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal If abnormal, please describe.			

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

(6.3) Medical questionnaire

This section must be completed with the medical information of all policy members, considering all current and previous conditions. Please make sure you declare everything about any condition and symptoms, known or suspected, even if you haven't yet sought medical care. The medical conditions listed are just examples of illnesses or conditions grouped according to body system, but do not limit or exclude other related conditions. If you are a current Bupa Global policyholder and would like to change your plan, you must also include your health information. This information will be reviewed by our underwriting team, who will evaluate the terms of your plan.

SECTION 1

An affirmative answer to any of the following must go to the next section.

1	Do you have or have you had an illness or accident in the last five years? Answer yes if you have an illness, even if you have not been hospitalised or admitted.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
2	Are you or have you been admitted to any hospital or undergone any surgery? Answer YES if you have been admitted or underwent surgery at any hospital or medical center for any reason	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
3	Are you currently under medication prescribed by a doctor? Answer YES, if you take any medication prescribed by a doctor	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
4	Do you currently persistently or repeatedly suffer any undiagnosed symptoms or pain? Answer YES if you have recently had any symptom or pain that has not been studied or diagnosed	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
5	Are you pregnant or have you ever been pregnant? If you answered "Yes", do you have or have you had any complications related to your pregnancy(s) (ectopic abortions/pregnancies/eclampsia/preeclampsia)? If yes, please complete the additional information section.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	

Habits: Does the applicant and/ or dependent(s) smoke cigarettes or consume products with nicotine, alcohol or illegal drugs? Yes No

Applicant(s) name	Type	Frequency
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SECTION 2

1	Heart or Circulatory system diseases (for example, hypertension angina/chest pain, heart attack, heart failure, irregular heart rate, aneurisms, varicose veins, among others)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
2	Endocrine System Disorders (for example, type 1 or type 2 diabetes or thyroid problems, among others)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
3	Respiratory System Disorders (for example, Asthma, COPD, respiratory infections, pneumonia or bronchitis, among others)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
4	Digestive Disorders - oesophagus, stomach, intestines, liver or gallbladder (for example, gastritis, gastric ulcer, haemorrhoids, pancreatitis, acute hepatitis, cirrhosis, gallstones, biliary colic or hernias, among others)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	
5	Dermatology - skin and appendages (for example, eczema, dermatitis, psoriasis, acne, among others)	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name	

6. MEDICAL INFORMATION (continued)

6	Neurological System - cerebral or nervous system (for example, multiple sclerosis, stroke, epilepsy, migraines, neuritis, hemi or paraplegia, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
7	Musculoskeletal system (for example, arthritis, back pain, spinal disorders, joint disorders, whether operated on or not, fractures, surgeries, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
8	Men's urology (for example, bladder, prostate or kidney diseases, urinary tract infections, renal colic due to kidney stones, incontinence among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
9	Women's urology/gynecology- urinary tract or gynecological diseases (for example, urinary infections, renal colic due to kidney stones, incontinence, ovarian cysts, mioma, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
10	Haematology or immunology- Blood or immunological diseases (for example, Lupus, Anemias, Autoimmune disorders, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
11	Diseases of the eyes, nose, ears or throat (for example, cataract, glaucoma, keratitis, sinusitis, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
12	Psychiatry and Psychology (for example: Schizophrenia, eating disorders, Bipolar Disorder, Autism, Attention Deficit Hyperactivity Disorder (ADHD), among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
13	Cancer and Lymphoproliferative disorders- Cancer of any location including Leukemia and Lymphomas, precancerous conditions (for example, cervical lesions, actinic keratosis, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Nombre de la(s) solicitante(s)				
14	Congenital diseases- congenital or inherited disorders of any kind (for example, Down Syndrome, cardiovascular or neurological malformations, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
15	Relevant infectious and/ or sexually transmitted diseases (for example, chronic hepatitis, tuberculosis, HIV/ AIDS, malaria, among others)				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				
16	Any other illnesses, disorders, injuries, accidents or pending surgery/hospitalization not mentioned above?				Yes <input type="checkbox"/> No <input type="checkbox"/>
	Applicant(s) name				

(6.4) Medical conditions/explanations

Letter		Applicant				Condition	
From	Month/Day/Year		To	Month/Day/Year	Treatment and results		
Current state of health					Doctor's information		
Letter		Applicant				Condition	
From	Month/Day/Year		To	Month/Day/Year	Treatment and results		
Current state of health					Doctor's information		
Letter		Applicant				Condition	
From	Month/Day/Year		To	Month/Day/Year	Treatment and results		
Current state of health					Doctor's information		

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

6. MEDICAL INFORMATION (continued)

(6.5) Medications

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			Amount	
Reason			Frequency			From Month/Day/Year	To Month/Day/Year
Applicant			Name of medication			Amount	
Reason			Frequency			From Month/Day/Year	To Month/Day/Year
Applicant			Name of medication			Amount	
Reason			Frequency			From Month/Day/Year	To Month/Day/Year
Applicant			Name of medication			Amount	
Reason			Frequency			From Month/Day/Year	To Month/Day/Year

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

(6.6) Habits

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

Applicant			Type		How long?		Amount per day	
Applicant			Type		How long?		Amount per day	
Applicant			Type		How long?		Amount per day	

(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. PAPERLESS CUSTOMER SIGN UP

I hereby sign up as a paperless customer with Bupa Insurance Company. As a paperless customer, I will receive all documents and correspondence from Bupa by logging into Online Services at www.bupasalud.com.

Applicant's email address

Applicant's email address	
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8. ACKNOWLEDGEMENT AND AUTHORIZATIONS

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.

Authorization to collect health information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to request my and/or my dependents' protected health information including, without limitation, my and/or my dependents' medical records, any prescription medication records/history, treatment records or plans, and any other medical or pharmaceutical information to be considered in the underwriting decision upon my and/or my dependents' application. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), and any other organization or person, including any member of my family having access to any medical records or knowledge of myself or my health, to disclose such information to Bupa, its Business Associates, or its designated agents (collectively, "Bupa Entities").

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa Entities will rely on such information to 1) underwrite this application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 3) administer coverage, and 4) conduct other insurance operations according to applicable law.

I understand that Bupa's ability to underwrite the insurance is dependent upon the receipt of all necessary health information. As such, my refusal to provide authorization (marking "No" below) will result in the rejection of my application for enrollment.

Yes No

Authorization to disclose health information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to use and disclose my policy conditions, certificate of coverage, and other insurance documents, payment information, claims filings, and medical records which may contain protected health information, to my insurance agent/agency and its affiliates and successors to enable them to respond to my inquiries and facilitate interactions regarding my insurance coverage, payments, and claims.

Yes No

I understand that:

- Bupa will use any information supplied in this application and received through this authorization prior to the effective date of coverage in considering my application.
- Bupa will comply with the Health Insurance Portability and Accountability Act of 1996 as amended and supplemented and the regulations thereto (HIPAA) and that the use and disclosure of information will be done under the applicable HIPAA statute and rules.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization shall be as valid as the original.
- The authorization shall be valid for the complete term of the coverage, including automatic renewal.
- This is a voluntary authorization, and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and no longer protected under HIPAA.
- I have the right to revoke this authorization by notifying Bupa in writing and subject to and in accordance with 45 C.F.R. §164.508. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:

Bupa Privacy Office
18001 Old Cutler Road, Suite 500
Palmetto Bay, Florida 33157 USA
Privacyoffice@bupalatinamerica.com

I have reviewed and understand the content and purpose of the acknowledgement and authorizations. By signing or replying affirmatively, I am confirming that the authorization decisions noted above accurately reflect my wishes. My signature below constitutes acceptance of all items listed above. This application is valid for 90 calendar days as of the date of signature.

By executing this application, I hereby acknowledge that, as the undersigned applicant for this policy, I have myself personally and physically filled out the information contained herein or used the services of the Master General Agent (MGA) identified below. I also hereby acknowledge that I have myself transmitted this application electronically, physically, or otherwise, to my authorized MGA at the authorized address below.

9. SIGNATURES

Applicant	Name	Signature	Date
Policyholder			Month/Day/Year
Spouse			Month/Day/Year

As Master General Agent (MGA) whose name and address appear below, or as an authorized representative of the MGA at that address, I acknowledge that the information contained herein was provided to our office solely by the applicant or that my office assisted the applicant in filling out the information contained herein. I acknowledge that my office shall be responsible for the collection of all premium payments and the delivery of any policy if and when it is issued.

Master General Agent's printed name	MGA's signature (witness)	MGA's code

Master General's Agent's authorized address	Country

10. PAYMENT INFORMATION (payment must be submitted with the application)

Policyholder's name	Policy No.			
Policy type:	<input type="checkbox"/> Annual	Premium:	US\$	
	<input type="checkbox"/> Semi-annual	Optional coverage:	US\$	
	<input type="checkbox"/> Quarterly	Annual administrative fee:	US\$	75.00
		Total amount:	US\$	

PAYMENT INFORMATION (continued)

Payment Method Option 1

Cashier's check Check Money order Traveler's check

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

Payment Method Option 2

Wire transfer

Bank information: Bupa Worldwide Premium Trust
Wells Fargo Bank, Cuenta #2000037371881, ABA #121000248, SWIFT #WFBUS6S, CHIPS #0407

Payment Method Option 3

ACH

Bank information: Bupa Worldwide Premium Trust
Wells Fargo Bank, Account #2000037371881, ABA #067006432

Payment Method Option 4

Credit card Please provide the following information:

I				
, authorize Bupa Worldwide Corporation to charge my credit card: <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 				
Credit card number		Expiration date	Month/Year	
Amount to charge: US\$		Identity card number (for Venezuela residents only)		
Cardholder's billing address (where the credit card statement is received): 				
Cardholder's telephone number:		Cardholder's signature		

Automatic debit for future renewals: Yes No

With my signature below, I hereby authorize Bupa Worldwide Corporation to debit the credit card 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 health insurance policy, the amount of the approved premium may also change. I further understand that a true and correct copy of this document will be forwarded to my credit card institution. By signing this document, I request and instruct such institution to allow Bupa Worldwide Corporation 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 premium is, for any reason, rejected or declined, I acknowledge that it will be my personal responsibility to immediately pay the premium of my health insurance policy or my policy may lapse, be cancelled and/or terminated.

By signing, I authorize automatic deductions for future renewals.

Policyholder's signature	Cardholder's signature	Date
		Month/Day/Year

CHECKLIST

BEFORE YOU SUBMIT THIS INTERNATIONAL HEALTHCARE SOLUTIONS INSURANCE APPLICATION, PLEASE MAKE SURE YOU HAVE INCLUDED ALL THE NECESSARY INFORMATION:

1. PERSONAL INFORMATION

- Fill out all the boxes with name, date of birth, height, and weight for each applicant.
- Make sure the information is legible.
- If the application includes full-time students ages 19 to 24, provide a certificate or affidavit from the college or university as evidence of full-time student status.
- If the application includes a person age 65 or older, please also complete Treating Physician Statement with all the required medical information.

2. PRODUCT, PLAN AND ADDITIONAL COVERAGE REQUESTED

- Make sure you select a product and deductible plan, as well as any additional coverage needed. If no additional coverage is selected, none will be granted.
- If requesting additional coverage for complications of maternity, please also complete a Maternity Questionnaire.

3. OTHER INSURANCE INFORMATION

- If you have health insurance with another company, please make sure you complete all the necessary information and attach a copy of the certificate of coverage, as well as receipt of last payment.

4. GENERAL INFORMATION

- Please make sure you provide a complete address, telephone, fax, and email information so we can contact you.

5. BENEFICIARY INFORMATION

- Please make sure you complete the section with your beneficiary information.

6. MEDICAL INFORMATION

- Please make sure you complete this section with information regarding family doctors, medical check-ups, medical conditions, medications, habits, and family history for all applicants. Questions answered with "Yes" need to be explained in section (6.4).

7. PAPERLESS CUSTOMER SIGN UP

- Select this option to sign up as a paperless customer and receive all your insurance documents online.

8. ACKNOWLEDGEMENT AND AUTHORIZATIONS

- Please read this section carefully and select "Yes" or "No" for both the Authorization to collect information and the Authorization to disclose health information. As indicated in this section, selecting "No" will result in the rejection of the application for enrollment.

9. SIGNATURES

- Make sure both Policyholder and Spouse (if applying for coverage) sign and date the application.

10. PAYMENT INFORMATION

- Make sure you complete all the information required in this section and select a payment method.
- Payment must be submitted together with the application.
- Select "Yes" if you would like Bupa to automatically debit your account for future renewals, and sign and date this section too.

THE APPLICATION IS VALID FOR 90 DAYS AS OF THE DATE OF SIGNATURE.