

Application for Insurance - The International Citizen Series



Part 1 Failure to provide complete information will delay processing.

	Deductibles	Dental Rider	Term Life	Sports Rider
Platinum	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Premier	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requested Effective Date (must be within 30 days of signature)		Premium (from Part 5): \$		

Note: Include only the family members applying for coverage. Attach additional sheets if necessary. Please print your name as you would like it to appear on your Identification Card.

Name (First name, middle initial, last name)		Date of Birth (mm/dd/yy)	Height	Weight	Citizenship
1. Applicant:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
2. Spouse:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
3. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
4. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
5. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			

RESIDENT ADDRESS OUTSIDE THE UNITED STATES
(required if US citizen)

MAIL FORWARDING ADDRESS FOR ALL WRITTEN
CORRESPONDENCE (if different from Residence)

Must include Street Address, City, State, Country, and Postal Code:	Must include Street Address, City, State, Country, and Postal Code:
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Your Occupation:	Employer Name:
Date Hired:	Prior Employment (if within 2 years):

Home Telephone Number:	Work Telephone Number:
Fax Number:	Email Address:

If you or any family member are a US citizen or if you are in the US now, the following information is required:

Date of departure from US:	Length of Residence outside of US:
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Part 2

Please answer all questions for all members of the family included in this Application. Provide details to all "Yes" answers in Part 3.	Yes	No
1. Have you ever had an application for health or life insurance voided, declined, cancelled, rescinded or modified (including medical exclusion riders)?		
2. In the last 24 months, have you used tobacco in any form? If yes, please specify type and frequency in Part 3.		
3. In the last 12 months, have you experienced a weight change of 15 pounds or more?		
4. In the last 5 years, have you had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any alcohol or drug related arrest?		
5. In the last 5 years, have you consumed alcoholic beverages in the excess of 14 drinks per week? If yes, please specify type and how much per week in Part 3.		
6. Are you pregnant or do you have an adoption pending?		
7. Do you (not including dependent children) read, write, speak and understand English? If no, what is your primary language?		
8. In the last 12 months, have you taken medication or received medical advice or treatment of any kind?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease or disorder of:	Yes	No
9. Gallbladder, pancreas, or liver?		
10. Skin?		
11. Joints or spine?		
12. Kidney?		
13. Eyes, ears, or nose?		
14. Mouth, throat, or jaw?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of:	Yes	No
15. High blood pressure?		
16. Chest pain?		
17. Headaches?		
18. Paralysis?		
19. Arthritis?		
20. Convulsions or epilepsy?		
21. Elevated cholesterol?		
22. Sexually transmitted disease?		
23. Cancer?		
24. Diabetes or sugar in the blood or urine?		
25. Stroke?		
26. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?		
27. Tumor, cyst, polyp, lump or growth of any kind?		
In the last 10 years, have you:	Yes	No
28. Had a complicated pregnancy or delivery?		
29. Tested positive for antibodies to the HIV virus?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional or received medical advice or treatment for a mental health condition?		
In the last 10 years, have you had any indications, signs, symptoms, diagnosis or treatment of any disease, disorder, or abnormality of the:	Yes	No
32. Heart or circulatory system?		
33. Nervous system?		
34. Digestive system?		
35. Muscular or skeletal system?		
36. Respiratory system?		
37. Male or female reproductive system?		
38. Urinary system?		
39. Thyroid, breast, or other glands?		
40. In the last 10 years, have you had any signs, indication, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse or abnormal test results?		

Part 3

For any question answered "Yes" in Part 2, please state the name of the family member (using the corresponding number from Part 1). Provide complete details of medical condition including: treatment dates, name, address and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Attach additional pages if necessary. Additional information may be requested.

#2 – Tobacco use (type and frequency of use)	#5 – Alcohol use (type and frequency of consumption)
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Individual's Name or Corresponding # from Part 1	Condition / Diagnosis	Dates of Treatment / Prognosis	Type(s) of Treatment and Present Course of Treatment	Physician and / or Facility Name, Address and Phone Number

Family History – Must be completed by all Applicants

Do you have a family history (mother, father, brother, and/or sister) of diabetes, cancer, heart disease, stroke, high blood pressure, and/or high cholesterol? Yes No If Yes, please provide relationship, condition, and indicate living or deceased, with age if deceased.

Part 4

For each family member applying for Term Life Insurance, please complete the following (Term Life is not available for those in the United States):	Coverage Elected
Applicant: Beneficiary:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Spouse: Beneficiary:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Child: Beneficiary:	<input type="checkbox"/> Option 1
Provide full address for each Beneficiary listed above (attach additional sheets if necessary):	
I understand Term Life Insurance will not become effective until the date of my departure from the US.	
_____ (Applicant initial here) _____ (Spouse initial here) _____ (Initial here for Dependent Children)	

Part 5

PREMIUM CALCULATION

Applications without premium will not be processed. We will not accept checks or money orders for Monthly, Quarterly or Semi-Annual payment modes. For Monthly, Quarterly or Semi-Annual payment modes we will only accept a pre-authorized credit card. Either checks or credit cards may be used for Annual payment mode. Please make all checks payable to: MULTINATIONAL UNDERWRITERS®.

Please enter premium amounts for the Medical portion (column 1) and any options elected (columns 2 through 4) below. Add the amounts in columns 1 through 4 for each individual and note the totals in column 5.

<p>(1) Medical: Enter the Annual Premium for each family member from the Rate Table for the Plan and Deductible selected.</p> <p>Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____</p> <p>Subtotal A: \$ _____</p>	<p>(2) Optional Dental Rider: Enter the Annual Premium for each family member electing the Optional Dental Rider from the Optional Dental Rate Table.</p> <p>Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____</p> <p>Subtotal B: \$ _____</p>	<p>(3) Optional Term Life: Enter the Annual Premium for each family member from the Optional Term Life and AD&D Insurance Rate Table:</p> <p>Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____</p> <p>Subtotal C: \$ _____</p>	<p>(4) Optional Sports Rider: Enter \$250.00 for each family member electing the Optional Sports Rider.</p> <p>Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____</p> <p>Subtotal D: \$ _____</p>	<p>(5) TOTAL: Add the amounts in columns 1-4 and note the total here.</p> <p>Applicant: \$ _____ Spouse: \$ _____ 1st Child: \$ _____ 2nd Child: \$ _____ 3rd Child: \$ _____</p> <p>Total E: \$ _____</p>
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Total First Payment Due

\$ _____	X	=	\$ _____
(Total E)		*Modal Factor	
*Modal Factors:	Annual 1.00	Semi-Annual .55	Quarterly .28 Monthly .20
	Optional Express mailing fee: (\$20 in US, \$30 outside the US)		\$ _____
	Total First Payment Due:		\$ _____

Remaining Payments (For Semi-Annual, Quarterly, or Monthly Payment Modes Only)

\$ _____	X	=	\$ _____
(Total E)		*Modal Factor	
*Modal Factors:	Semi-Annual .55	Quarterly .28	Monthly .10
	Premium Due For Each Additional Installment :		\$ _____
<p>Monthly payments are available only if valid email address is provided: _____</p> <p>All correspondence regarding monthly payments will be made via email to this address. For Monthly Payment mode, there will be 10 additional monthly payments after initial payment. If you elect monthly payments, the 11 payments will be drawn during the first 11 months of coverage.</p>			

Part 6

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to Members by Lloyd's. I have personally completed this Application. I represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I understand MultiNational Underwriters® relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meet the Underwriting and Eligibility requirements of the plan. I understand that any misrepresentation or omission contained herein will void my insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by MultiNational Underwriters®. I understand that if this Application is not accepted, the sole obligation of MultiNational Underwriters® is to return any premium I have paid to me. I understand that this insurance contains a Pre-existing Condition Exclusion, a Pre-notification Penalty, and other restrictions, exclusions and limitations. I understand that I may obtain a copy of the Master Policy upon request to MultiNational Underwriters®. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand that the insurance agent/broker, if any, assisting me with this Application, is a representative of the Applicant. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis or physical or mental condition of any family member listed on this Application to release said information to MultiNational Underwriters®.

Signature of Applicant, Guardian, or Power of Attorney

Signature of Spouse

Date of Signature

Date of Signature

Method of Payment

Check or Money Order (Annual Payments only) American Express Discover MasterCard VISA

Check or Money Orders should be made payable, in US dollars, to MultiNational Underwriters®. All payments must be made in US dollars. If paying by Credit Card, I authorize MultiNational Underwriters® to debit my VISA/Mastercard/American Express/Discover account for the total amount due. If I have selected Monthly, Quarterly, or Semi-Annual payment modes, I hereby request and authorize MultiNational Underwriters® to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for up to 12 months or longer if the Certificate is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card company.

Credit Card Number:

Expiration Date (mm/yy):

Name as it appears on card:

Billing Address:

Daytime Phone Number:

Signature:

Part 7

Producer Number: 22342	Producer Name: Chiranth Nataraj	
Company Name: International Services, Inc.	Street Address: #756, 1655 North Fort Meyer Drive, Ste#700	
City: Arlington	State: VA	Postal Code: 22209
Country:	Telephone: 877-593-5403	Fax: 877-593-5403
E-mail Address: insurance@nriol.net	Signature:	

THIS MEDICAL, DENTAL AND LIFE INSURANCE IS UNDERWRITTEN BY CERTAIN UNDERWRITERS AT LLOYD'S, LONDON AND IS AVAILABLE TO MEMBERS OF THE ATLAS/INTERNATIONAL CITIZENS GROUP INSURANCE TRUST, HAMILTON, BERMUDA. LLOYD'S IS AN APPROVED NON-ADMITTED INSURER IN ALL STATES OF THE UNITED STATES, EXCEPT KENTUCKY AND ILLINOIS WHERE THEY ARE ADMITTED. CLAIMS UNDER THIS INSURANCE MAY NOT BE MADE AGAINST ANY STATE GUARANTY FUND.