GLOBAL BENEFITS GROUP
Insurance Without Borders

NAVIGATOR
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Application for Individual Coverage

Instructions:

1. **You are responsible for completing this application and are solely responsible for its accuracy and completeness.**
2. **All questions must be answered in full; all signatures and dates must be included where noted; otherwise the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.**
3. **Type or print clearly using blue or black ink.**

Note: You may also apply online at www.gbg.com

Applicant's Name:	

Section 1: Insurance Policy Selection: Please complete this section to tell us what insurance you are interested / applying for.

Enrollment Type: ☐ New Enrollment ☐ Add Spouse, Date of Marriage: _____ ☐ Add Child ☐ Other_____

Currency of Benefits: ☐ **HKD. Dollar**

Medical Insurance Coverage

Choose One:	☐ Worldwide (No Area Exclusions) ☐ International (No Coverage in U.S. or Canada) ☐ International Plus (Emergency Coverage in U.S. or Canada)
Annual Deductible:	☐ $100 ☐ $250 ☐ $500 ☐ $1,000 ☐ Other _____
Co-insurance:	☐ 0% ☐ 10% ☐ 20% ☐ 30%

Method of Payment:	☐ Annual ☐ Semi-Annual **(add 5% surcharge)** ☐ Quarterly **(add 5% surcharge)** ☐ Monthly **(add 5% surcharge)**

Application for Individual Coverage

Please complete sections 2 through 5 to provide additional information about yourself and your dependents (if applicable).

Section 2-A: Applicant Details

Last Name:	First Name:	Gender: Male Female	Height / Weight: feet / m: lbs / kgs:	Marital Status: Single / Married / Domestic Partner / Divorced / Widowed
Date of Birth (dd/mmm/yyyy):	Citizenship (if dual, provide both):	Passport # or National Identity Card #:		Nationality (Place of Birth):

Date of Departure for International Assignment:	Country of Residence While on Assignment:	Anticipated Length of Assignment:		
Address:	City:	State:	Postal Code:	Country:
Email Address:	Have you ever been covered by TieCare / Global Benefits Group Before? ☐ Yes ☐ No			

Employer Name:	Employer Address:	
Annual Salary (Specify Currency):	Occupation and Title (Please provide full description):	
Date of Hire (dd/mmm/yyyy):	Number of Hours Worked per Week:	**Requested Effective Date (dd/mmm/yyyy):**

Section 2-B: Dependent Information (Complete below only if enrolling dependents)

Relationship:	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:
Relationship: **Spouse**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:
Relationship: **Child**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:
Relationship: **Child**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:
Relationship:	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:
Relationship:	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: Male Female	Country of Residence:	Height / Weight: feet / m: lbs / kgs:

Section 2-C: Travel Pattern

Anticipated travel pattern for the next 12 months.

Destination	Frequency	Duration	Duties

Section 3-A: Medical Questionnaire: Please complete for all members applying for coverage.

1) Within the past 10 years, have you or any dependent been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following?		
1A) Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system?	Yes	No
1B) Mental retardation; any mental, behavioural, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counseling or therapy?	Yes	No
1C) High blood pressure; heart attack, stroke, chest pain or palpitations, murmur, varicose veins, blood clot, anemia, or any other blood heart, or circulatory disorder or condition? If yes, most recent blood pressure reading _____. Date recorded _____	Yes	No
1D) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	Yes	No
1E) Colitis; chronic diarrhea, or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition?	Yes	No
1F) Cancer, tumor, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder?	Yes	No
1G) Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection?	Yes	No
1H) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear?	Yes	No
1I) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	Yes	No
1J) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement?	Yes	No
1K) Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state Type _____ and most recent blood sugar reading _____. Date recorded _____	Yes	No
1L) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder?	Yes	No
1M) Alcoholism; alcohol, drug or substance abuse or dependency?	Yes	No
1N) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	Yes	No
2) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed?	Yes	No
3) Are you currently pregnant? Expected Due Date: _____	Yes	No
3A) If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy?	Yes	No
3B) Is this pregnancy the result of infertility treatment?	Yes	No
4) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	Yes	No
5) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	Yes	No
6) Have you been hospitalized in the last 10 years for any reason?	Yes	No
7) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above?	Yes	No
8) Do you engage in any profession, sport, or hobby that could be considered hazardous?	Yes	No
9) Do you receive any disability pension or work accident pension?	Yes	No

Section 3-B: Medical Questionnaire: Give details of each item answered "Yes" in Section 3-A.

(If more space is needed, attach separate page, which must be signed and dated)

Name	Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates From/To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

Section 3-C: Medication: List all medications that are currently prescribed for you or a family member.

Member Name	Medication Name	Dosage	Frequency	Reason For Use

Section 4: Medical Practitioner: Please provide details of your family Doctor, if you have one.

Name:	Mailing Address:	Phone Number:

Section 5: Life Beneficiary Information (Applicable if applying for Life Insurance)

Name:	Address:
Relationship:	% of Benefit:
Name:	Address:
Relationship:	% of Benefit:

Section 6: Residence Verification (Please complete Residence Verification Form for your dependents if residency is different from you)

I understand by signing this Application, that I, _____ am certifying ☐ I am ☐ I am NOT residing in the United States. I understand that I must notify Global Benefits Group / TieCare International immediately of any change in my and/or my dependents' residency. Failure to do so may result in the denial of claims as well as recovery of any claims already paid.
I will submit an address change directly to your main office located at: 26000 Towne Centre Drive, Suite 100, Foothill Ranch, CA 92610 USA. Phone: (949) 470-2100; Fax: (949) 457-3116; Email: enroll@gbg.com

_____
Applicant Signature

Section 7: Representations, Acknowledgements, and Authorizations

I, the Undersigned Hereby:

1. Declare that the foregoing answers to the best of my knowledge and belief are true and accurate and are offered as an inducement to grant insurance.
2. Declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days in the preceding twelve months.
3. Agree that there shall be no insurance until the Insurer has approved this application.
4. Authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.
5. Understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Applicant Signature Date Signed

Fax completed application to +949-457-3116 or Email to enroll@gbg.com

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