Application for **Group Employee Health Insurance (FMU)**

This application is a legal document that must be read and completed in its entirety, as well as signed by the applicant and their agent.
If you have any existing medical condition, you must declare it in detail on pages 2, 3, 4 and 5, Section 5.
Applicants who are 65 years of age or older must provide the Attending Physician Statement properly completed and signed by their physician. If the information provided is incomplete or unsigned, it might cause delays in the underwriting process and the issuance of the policy. In addition, VUMI® reserves the right to contact the applicant and/or his/her doctor.

New policy | Policy reinstatement | Dependant addition | Change of plan/option | VUMI® policy number:

Section I. **Policyholder** Information

1. Name of employer:
2. Last name(s) of policyholder:
3. First name of policyholder:
4. Middle initial:
5. Occupation:
6. Address:
7. Post Code/P.O. Box:
8. City:
9. State:
10. Country of residence:
11. Email address:
12. Phone number (office or mobile):
13. Fax:
14. Gender: Male Female
15. Date of birth: D D / M M / Y Y Y Y
16. Marital status: Single Married Divorced Widowed
17. Height: Meters Feet
18. Weight: Kilos Pounds
19. Country of nationality:
20. If this application includes dependants between the ages of 18 and 28 years old:
Are any of them a full-time university student? Yes No

20a. If you answered **"Yes,"** please provide the name of the school and a copy of the university's certificate or affidavit as evidence that they are full-time students:

Section II. **Dependant** Information

Spouse, biological children, stepchildren, or legally adopted children by the policyholder or to whom the policyholder has been named a legal guardian (children must be single)

DEPENDANT 1

1. Last name(s):
2. First name:
3. Relationship to the policyholder:
4. Date of birth: D D / M M / Y Y Y Y
5. Nationality:
6. Gender: Male Female
7. Height: Meters Feet
8. Weight: Kilos Pounds

DEPENDANT 2

1. Last name(s):
2. First name:
3. Relationship to the policyholder:
4. Date of birth: D D / M M / Y Y Y Y
5. Nationality:
6. Gender: Male Female
7. Height: Meters Feet
8. Weight: Kilos Pounds

DEPENDANT 3

1. Last name(s):
2. First name:
3. Relationship to the policyholder:
4. Date of birth: D D / M M / Y Y Y Y
5. Nationality:
6. Gender: Male Female
7. Height: Meters Feet
8. Weight: Kilos Pounds

If you need to include more dependants, ask your agent for the Dependant Information Annex and attach it to this application.

Section III. **Choose** your Cover

1. Proposed effective date:

D D / M M / Y Y Y Y

2. Plan:

- Global Flex VIP Total
- Global Flex VIP Superior
- Global Flex VIP Basic
- Global Flex VIP Ultra
- Global Flex VIP Standard

3. Area of cover:

- Worldwide including USA elective treatment
- Africa area of cover restriction
- Indian sub-continent area of cover restriction
- Worldwide excluding USA
- Asia area of cover restriction

4. Optional benefits

- Evacuation to country of choice, country of residence or home country
- Non-Emergency evacuation
- Wellness and optical (not available for Global Flex VIP Basic):
  - Option I - US$500
  - Option II - US$1,000

5. Deductible, Outpatient per visit Excess and Outpatient Coinsurance Options:

- US$0
- US$1,000
- US$2,000
- US$5,000
- US$10,000
- US$15,000
- US$20,000

Not available for Global Flex VIP Basic

- US$15 Outpatient Per Visit Excess
- US$30 Outpatient Per Visit Excess
- 10% Outpatient Coinsurance, up to a maximum out of pocket of US$2,000
- 20% Outpatient Coinsurance, up to a maximum out of pocket of US$4,000
- 30% Outpatient Coinsurance, up to a maximum out of pocket of US$6,000

Section IV. **Prior Cover** Information

1. Do you have health insurance with another company? Yes No

1a. Name of the company:

1b. Phone number: +

1c. Plan:

1d. Deductible amount:

1e. Policy number:

1f. Do you plan to keep the health insurance with the other company? Yes No

1g. Have you previously had medical coverage with VUMI® or any of its affiliates? Yes No

1h. If you answered "Yes," please indicate your policy number:

Section V. **Medical** Information

Part A: Medical Exams

1. Have any of the applicants had any exam other than a routine examination in the past 5 years? If yes, please indicate: Yes No

1a. Full name of the applicant:

1b. What type of exam?

1c. What was the reason for the exam?

1d. Results of the exam:

1e. Are you currently undergoing other exams to confirm a diagnosis? Yes No

2. Have any of the applicants had any medical consultations in the past 9 months? If yes, please indicate: Yes No

2a. Full name of the applicant:

2b. What type of medical consultation?

2c. Were there exams conducted as a result of this consultation? If yes, please detail which exams:

Yes No

2d. Results of the exams:

3. Have any of the applicants suffered an accident? If yes, please indicate: Yes No

3a. Full name of the applicant:

3b. What type of accident? Is the applicant currently under treatment due to this accident? Yes No

3c. Are there any consequences to the applicant's health due to this accident? If yes, please explain: Yes No

3d. Does the applicant use any orthopaedic device? Yes No

4. Have any of the applicants had a paediatric, gynaecological or routine exam in the last 5 years? If yes, please indicate: Yes No

MEDICAL EXAM 1

1. Full name of the applicant:

2. Type of examination:

3. Date: D D / M M / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please provide the results: Yes No

MEDICAL EXAM 2

1. Full name of the applicant:

2. Type of examination:

3. Date: D D / M M / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please provide the results: Yes No

MEDICAL EXAM 3

1. Full name of the applicant:

2. Type of examination:

3. Date: D D / M M / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please provide the results: Yes No

Part B: Medication

Have any of the applicants been prescribed or are currently under treatment with any medication? If yes, please indicate: Yes No

MEDICAL TREATMENT 1

1. Full name of the applicant:

2. From: D D / M M / Y Y Y Y

3. To: D D / M M / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 2

1. Full name of the applicant:

2. From: D D / M M / Y Y Y Y

3. To: D D / M M / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 3

1. Full name of the applicant: *2. From:* D D / M M / Y Y Y Y *3. To:* D D / M M / Y Y Y Y

4. Name of the medication, dose and frequency:

Part C: Medical Conditions

To the best of your knowledge and understanding, have any of the applicants received medical treatment, or had any diagnostic tests and/or suffered from any of the following diseases?

1 Nasal, vision, ear or throat disorders — Yes No

2 Seizures, migraines, paralysis or other neurological disorders — Yes No

3 Heart disorders, circulatory disorders, hypertension, high cholesterol or triglycerides — Yes No

4 Allergies, asthma, bronchitis, pneumonia, lung disorder or other disorders of the respiratory system — Yes No

5 Diseases of the esophagus, stomach, intestines, pancreas, gall bladder, hepatitis or other liver diseases as well as other disorders of the digestive system — Yes No

6 Kidney or urinary tract diseases — Yes No

7 Spine diseases or injuries, rheumatism, arthritis, gout or other muscular, joints or bone disorders — Yes No

8 Cancer or benign tumors — Yes No

9 Anemia, leukemia, lymphoma, coagulation disorders or other blood disorders — Yes No

10 Diabetes, thyroid gland disorders or other endocrine/hormonal disorder — Yes No

11 Skin diseases — Yes No

12 Congenital or hereditary disorders — Yes No

13 Sexually transmitted diseases or sexual organs or other reproductive system disorder — Yes No

14 Prostate diseases — Yes No

15 Breast, ovaries, uterus or other gynecological disorders — Yes No

16 Is the main applicant or any of the dependants currently pregnant? (if yes, please provide the expected due date): — Yes No

D D / M M / Y Y Y Y

17 Has the main applicant or any of the dependants been pregnant? (if yes, please complete): — Yes No

17a. Number of pregnancies: *17b. Deliveries:* *17c. C-sections:* *17d. Abortions:*

18 Pregnancy or delivery complications, multiple pregnancy, newborn complications including, but not limited to congenital or hereditary conditions (if yes, provide details below and in Part D) — Yes No

18.1 Please detail medical conditions related to the mother:

18.2 Please detail medical conditions related to the newborn(s):

18.3 Please detail medical complications related to multiple pregnancy(ies) (specify if it was a natural pregnancy or with assisted reproductive technology):

19 Have any of the applicants had any other illness, condition, injury, accident, surgery, medical consultation, diagnosis, involuntary weight loss or hospitalisation not listed above? — Yes No

Part D: Explanation of Medical Conditions (declared in Part C of this application)

MEDICAL CONDITION 1

1. Number: *2. Full name of the applicant:* *3. Illness or injury:*

4. From: D D / M M / Y Y Y Y *5. To:* D D / M M / Y Y Y Y *6. Name of the physician:*

7. Physician's phone number: +

8.Treatment:

9. Result of the treatment:

10. Current condition of the illness or injury (e.g., it is under treatment, disappeared or controlled)

MEDICAL CONDITION 2

1. Number:

2. Full name of the applicant:

3. Illness or injury:

4. From: D D / M M / Y Y Y Y

5. To: D D / M M / Y Y Y Y

6. Name of the physician:

7. Physician's phone number: +

8.Treatment:

9. Result of the treatment:

10. Current condition of the illness or injury (e.g., it is under treatment, disappeared or controlled)

MEDICAL CONDITION 3

1. Number:

2. Full name of the applicant:

3. Illness or injury:

4. From: D D / M M / Y Y Y Y

5. To: D D / M M / Y Y Y Y

6. Name of the physician:

7. Physician's phone number: +

8.Treatment:

9. Result of the treatment:

10. Current condition of the illness or injury (e.g., it is under treatment, disappeared or controlled)

Part E: Habits

Do any of the applicants use or have used nicotine products, alcoholic beverages or illegal drugs? If yes, please indicate: Yes No

TYPE OF HABIT 1

1. Full name of the applicant:

2. Product and amount consumed per day:

3. From - To (month/year): M M / Y Y - M M / Y Y

TYPE OF HABIT 2

1. Full name of the applicant:

2. Product and amount consumed per day:

3. From - To (month/year): M M / Y Y - M M / Y Y

TYPE OF HABIT 3

1. Full name of the applicant:

2. Product and amount consumed per day:

3. From - To (month/year): M M / Y Y - M M / Y Y

Any exam, treatment, and/or consultation carried out by the policyholder or any of his/her dependants before submitting the application, or during the underwriting process (if applicable), or the approval process, until the effective date of the policy, must be communicated to VUMI® Group, I.I. in order to add this information to the application. Likewise, any accident and/or symptom that occurred or manifested during this period, must be communicated to the company in order to take this new information into consideration for the approval of the coverage and the issuance of the corresponding documents.

Failure to provide this information will be considered as a sign of bad faith when accepting the policy's contractual obligations and VUMI® Group, I.I. reserves the right to take the pertinent actions.

Section VI. **Family** History

1. Do any of the applicants have a family history of diabetes, hypertension, heart disorders, cancer or congenital or hereditary diseases? If yes, please indicate:

Yes No

FAMILY HISTORY 1

1. Full name of the applicant:	*2. Relationship to the policyholder:*	*3. Disease:*

FAMILY HISTORY 2

1. Full name of the applicant:	*2. Relationship to the policyholder:*	*3. Disease:*

2. If any of the applicants are adopted, do you know his/her family medical history? If yes, indicate:

Yes No

FAMILY HISTORY 1

1. Full name of the applicant:	*2. Relationship to the policyholder:*	*3. Disease:*

FAMILY HISTORY 2

1. Full name of the applicant:	*2. Relationship to the policyholder:*	*3. Disease:*

Section VII. **Claims** Reimbursement Method

Please indicate how you would like to receive claim reimbursement payments. We remind you that bank transfers are the fastest and safest method for this purpose:

Bank Transfer

FOR BANK TRANSFER

1. Bank account holder's full name:

2. Country:	*3. Bank name:*
4. Bank address:	*5. Bank currency:*
6. IBAN or account number:	*7. SWIFT code:*
8. ACH/RT (only for Bank of America):	*9. ABA:*

Section VIII. **Acknowledgement** and Authorisations

I have read, fully understand, and freely and voluntarily sign as my acceptance of the contents of this application. I declare that the personal and medical information I have included in this application is true, complete and accurate, and I affirm that I have not omitted, concealed, modified or altered this information. I am fully aware and accept that in case of any omission, concealment, modification or alteration of the information declared in this application, or information that has not been subsequently declared up until the effective date of the policy, will be considered an act of bad faith when accepting my contractual obligations, and may cause claims to be denied, or put on hold until the beneficiary(ies) complete the required information, and the policy to be modified, rescinded or canceled, for which a written communication from VUMI® Group, I.I. will suffice. VUMI® Group, I.I. reserves the right of taking legal and administrative action in case of any indemnities.

I understand the Company reserves the right to reject this application based on the information I submitted regarding my or any of the applicants' residence or health, or for any other reasons the Company considers relevant. This application is valid for sixty (60) days from the day it was signed. If I want to withdraw my application from the underwriting process, I will have to send a written notification to VUMI® Group, I.I. or its authorised representatives within fifteen (15) days of the subscription of the application.

I understand I am applying for international medical insurance cover that may not provide mandatory benefits required by regulations of the country of residence or any other jurisdictions. If I am not satisfied with the cover offered, I can notify my employer.

Authorisation to collect and disclose health information of the applicants

I hereby authorise VUMI® or VUMI® Group, I.I., its subsidiaries and any affiliated companies or its designated representatives to request my medical records and/or those of my dependants, as well as any prescription medication history and any other medical or pharmaceutical information to be considered in the underwriting process regarding the application for individual health insurance coverage for myself and my dependants.

I authorise any physician, hospital, laboratory, pharmacy or other medical provider, insurance company, if I had a prior or another medical coverage, government agencies, employee or benefit plan administrator, organisation whom I represent and from whom I have legal authorisation, and person, including any family member who has medical records or knowledge of me and/or my dependants or our health, to disclose such information to VUMI® or VUMI® Group, I.I. or its designated representatives. Likewise, I hereby authorise VUMI® or VUMI® Group, I.I., its subsidiaries and any affiliated companies or its designated representatives to disclose to my insurance agent, affiliates and successors the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage, payments and claims. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorisation and that information, once disclosed, may no longer be protected by federal laws of the United States governing privacy and confidentiality.

The existence of any information and documentation described above shall be disclosed with this application. I understand that VUMI® will use this information to: 1) assess the risk of application for coverage and make decisions about eligibility, risk rating, policy issuance and registration of all applicants; 2) provide benefits and process a claim; 3) administer coverage; and 4) conduct other insurance operations according to applicable law.

A copy of this authorisation will be considered as valid as the original. I understand that the ability of VUMI® to assess coverage is based on receiving all necessary personal and health information.

Privacy

All personal medical information will be treated as confidential by VUMI® Group, I.I., its affiliated companies or its designated representatives. The Company complies with the Data Protection legislation and the confidentiality of the medical information rules and regulations. The Company will not share any medical information, unless an authorisation to do so exists, whether by the patient, his/her legal representative(s) or the law.

Governing Law

This application form shall be governed by and construed in accordance with the law of Florida, excluding Florida's choice of law rules.

I hereby consent and acknowledge my express agreement to the terms set forth in the insurance application regarding arbitration and governing jurisdiction of any claims I may have during the existence of the policy I am applying for, and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward.

1. Full name of the policyholder:	2. Policyholder's signature:	3. Date:
	X..	D D / M M / Y Y Y Y
4. Full name of the spouse:	**5. Spouse's signature:**	**6. Date:**
	X..	D D / M M / Y Y Y Y

TO BE COMPLETED BY THE AGENT

To the best of my knowledge, I do not know of the existence of any condition that has not been disclosed in this application that could affect the insurability of the proposed insureds.

7. Full name/code of the Agent:	8. Agent's signature:	9. Place and date *(day / month / year)*:
	X..............................	D D / M M / Y Y Y Y

VUMI® GROUP, I.I.
ORGANISED UNDER CHAPTER 61 OF THE PUERTO RICO INSURANCE CODE.
NO COVERAGE ISSUED BY THIS INSURER IS PROTECTED BY ANY GUARANTEE OR INSOLVENCY FUND IN PUERTO RICO.
Administration services provided by VUMI Global Services FZ-LLC

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