Application for **Group Health Insurance**

Policy number (for internal use only):

Section I. **General** Information

1. Full legal name of company (Employer):
2. Company address (street, post code / P.O. box, city, state, country):
3. Number of years in business:
4. Type of business:
5. Business telephone:
6. Fax:
7. Web address:
8. Name of administrative contact:
9. Title:
10. Phone:
11. Email:
12. Proposed start date of the group policy:

D D / M M / Y Y Y Y

Note: Employees not actively at work as of the application date will not be covered until they return to work. Please list all eligible employees not actively at work as of the application date (attach a separate sheet with listed names, if necessary):

Section II. **Underwriting** Options

Full Medical Underwriting (FMU) Continuous Transfer Terms (CTT) Medical History Disregarded (MHD) *Available for groups of ten (10) employees or more.*

If MHD selected, please answer the following.

To the best of your knowledge, has any employee or dependant to be included in this policy been diagnosed with, or received any form of treatment/consultation for cancer in the past five years? Yes No

To the best of your knowledge, does any employee or dependant to be included in this policy have any medical condition that is likely to result in the need for an in-patient stay in hospital? Yes No

Section III. **Current Insurance** Policy

1. Policy number:
2. Date cover expires/expired: D D / M M / Y Y Y Y
3. Name of Insurer:

Section IV. **Eligibility**

1. Employee options:

Employee only Employee and dependants

Is participation mandatory (meaning all eligible employees (and dependants, if applicable) must be enrolled)? If not, please give details of any voluntary participation Yes No

Section IV. **Eligibility** **(continued)**

CONTRIBUTION BASIS (%)

CATEGORY	EMPLOYER	EMPLOYEE
A		
B		
C		

COVERED CLASSES *(Please list eligible job classes and describe eligible jobs if plan varies by class)*

CATEGORY	CATEGORY DESCRIPTION	NUMBER OF ELIGIBLE EMPLOYEES	PLAN REQUIRED
A			
B			
C			

If your group will have more than one category, please include job titles of eligible employees for each. When applying for Cover, employees must be full-time (min. 25 hours a week) active employees. The maximum age to apply for Cover is seventy-four (74). If we accept a group plan on a compulsory participation or contribution basis and learn subsequently that the group policy is on a voluntary basis, we reserve the right to adjust the premium.

Section V. **Plan** Options

Plan	Global Flex VIP Basic	
	Global Flex VIP Standard	
	Global Flex VIP Superior	
	Global Flex VIP Ultra	
	Global Flex VIP Total	
	Travel VIP	
Deductible, Outpatient Per Visit Excess and Outpatient Coinsurance Options	**OPTION I**	US$0 deductible
	OPTION II	US$1,000 deductible
	OPTION III	US$2,000 deductible
	OPTION IV	US$5,000 deductible
	OPTION V	US$10,000 deductible
	OPTION VI	US$15,000 deductible
	OPTION VII	US$20,000 deductible
	Not available for Global Flex VIP Basic	
	OPTION VIII	US$15 Outpatient Per Visit Excess
	OPTION IX	US$30 Outpatient Per Visit Excess
	OPTION X	10% Outpatient Coinsurance, up to a maximum out of pocket of US$2,000
	OPTION XI	20% Outpatient Coinsurance, up to a maximum out of pocket of US$4,000
	OPTION XII	30% Outpatient Coinsurance, up to a maximum out of pocket of US$6,000
Area of Cover	Worldwide including USA elective treatment	
	Worldwide excluding USA	
	Africa area of cover restriction	
	Asia area of cover restriction	
	Indian sub-continent area of cover restriction	

Optional Benefits	Evacuation to country of choice, country of residence or home country		
	Non-emergency evacuation		
	Semi-private room		
	Wellness and optical (not available for Global Flex VIP Basic)	**OPTION I**	US$500
		OPTION II	US$1,000
Maternity *Only available for Global Flex VIP Standard for groups of five (5) employees or more.*	**OPTION I** US$5,000	No Coinsurance	
		20% Coinsurance	
	OPTION II US$7,500	No Coinsurance	
		20% Coinsurance	
Dental *Only available for Global Flex VIP Standard and Superior, and for groups of five (5) employees or more.*	**OPTION I** Up to US$500 for routine and US$1,000 for major dental treatments	No Coinsurance	
		20% Coinsurance on routine dental, 50% Coinsurance on major dental	
	OPTION II Up to US$750 for routine and US$1,500 for major dental treatments	No Coinsurance	
		20% Coinsurance on routine dental, 50% Coinsurance on major dental	
Outpatient Treatment *Only available for Global Flex VIP Basic*	**OPTION I** Up to US$5,000 for defined Outpatient treatment		
	OPTION II Up to US$5,000 for defined Outpatient treatment including routine management of pre-existing and chronic conditions		
Bespoke Benefits *As agreed and included in the quotation*			

Section VI. **Broker / Consultant** Details

1. Date: D D / M M / Y Y Y Y

2. Agent name:

3. Company /Agency:

4. License # / Broker code:

5. Phone:

6. Fax:

7. Email:

Section VII. **Census** Data

Please submit census data in the Excel sheet attached for eligible employees and eligible dependants (if applicable) for plans with family Cover.

Section VIII. **Administration**

This is an annual policy with premium due and payable on an annual basis. Rates are subject to change as of the renewal date. Cancellations can be given within 30 days through written notice; however termination will occur as of the subsequent anniversary.

For administrative purposes, premiums can be remitted using alternative payment frequencies. Please indicate which payment frequency is requested:

Annually Semi-Annually Quarterly

Section VIII. **Administration**

For plans that require employees to pay the premium (in whole or part) for spousal and/or family Cover, employees must sign and date an acknowledgment letter if spousal or family Cover is offered and declined. Employees have 30 days from the day they are first eligible to apply for dependant Cover. Please indicate the contribution required by the employee (if any) for Cover:

Section IX. **Acknowledgement** and Authorisations

We, the Employer, have read, fully understand, and freely and voluntarily accept the contents of this group application. We declare that all information provided herein, including any personal, corporate, and medical private information details submitted with the proper authorisation of our employees and their dependants, is true, complete, and accurate. We further confirm that no relevant information has been omitted, concealed, or altered. The Employer acknowledges and accepts that any omission, concealment, modification, misrepresentation or incorrect statement, whether in this application or up to the effective date of the policy, will be considered an act of bad faith and may cause claims to be denied or delayed, or the policy to be modified, rescinded, cancelled, or voided. Such actions may also alter rates at inception if the information is fraudulent or material to the risk assumed by the insurer, or if the insurer, in good faith, would not have issued or maintained the policy had the true facts been known. VUMI® Group, I.I. reserves the right to take legal and administrative action in such cases.

We understand the Company reserves the right to reject this application based on the information we provided or for any other reasons the Company considers relevant. This application is valid for sixty (60) days from the day it was signed. If we would like to withdraw this application from the underwriting process, we will send a written notification to VUMI® Group, I.I. or its authorised representatives within fifteen (15) days of the subscription of the application.

We acknowledge that this international medical insurance may not provide mandatory benefits required by the laws of the country of employment, incorporation, or residence.

Authorisation to collect and disclose health information of the applicants

As the Employer, we authorise VUMI® or VUMI® Group, I.I., its subsidiaries and any affiliated companies or its designated representatives to request, collect, use, and disclose medical information and records of the employees and their dependants included in this group application, for the purposes of underwriting, policy administration, eligibility determination, and claims processing.

We authorise any physician, hospital, laboratory, pharmacy or other medical provider, insurance company, government agencies, employer or benefit plan administrator, or other organisation that holds relevant information to release such records to VUMI® or VUMI® Group, I.I. or their authorised representatives. We further authorise VUMI® or VUMI® Group, I.I., its subsidiaries, and affiliates to disclose relevant policy information, including certificates of coverage, payment history, claims, and reimbursement details, to the group's appointed insurance broker or administrator to facilitate policy servicing and communication.

We understand that once disclosed, certain information may no longer be protected by federal privacy laws of the United States. We acknowledge that VUMI® will use such information solely 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.

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.

The Employer hereby consents to and expressly agrees to the terms set forth in this insurance application regarding arbitration and governing jurisdiction of any claims that may arise during the existence of the group policy or any subsequent amendments thereto. The Employer understands that this consent shall remain in force for the duration of the policy and any renewals or changes thereafter.

1. Full name of the main applicant:	2. Main applicant's signature:	3. Place and date *(day / month / year)*:
	X..	D D / M M / Y Y Y Y
4. Witness':	**5. Witness' signature:**	**6. Place and date *(day / month / year)*:**
	X..	D D / M M / Y Y Y Y

On behalf of
(Entity/Company)

I confirm that all statements made in this application are true and correct.

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 Cover ISSUED BY THIS INSURER IS PROTECTED BY ANY GUARANTEE OR INSOLVENCY FUND IN PUERTO RICO.
Administration services provided by VUMI Global Services FZ-LLC

Office 103, Building 7. Dubai Outsource City. Dubai United Arab Emirates | PO Box. 345807
Phone number: +971.4.573.2900 | Fax number: + 971.4.514.1689
infoglobal@vumigroup.com • www.vumiglobal.com