For company use
Policy number

Individual Health 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 plan

❶ PERSONAL INFORMATION

Name of applicants (policyholder/dependents)	Relationship to policyholder	Marital status[1]	Date of birth Month/Day/Year	Sex	Weight	Height
First name M.I. / Last name	Self		/ /	❍ ❍ M F	❍ ❍ lbs kg	❍ ❍ ft m
First name M.I. / Last name			/ /	❍ ❍ M F	❍ ❍ lbs kg	❍ ❍ ft m
First name M.I. / Last name			/ /	❍ ❍ M F	❍ ❍ lbs kg	❍ ❍ ft m
First name M.I. / Last name			/ /	❍ ❍ M F	❍ ❍ lbs kg	❍ ❍ ft m
First name M.I. / Last name			/ /	❍ ❍ M F	❍ ❍ lbs kg	❍ ❍ ft m

If this Application includes children **between 19 and 24 years old**, are any of them a full-time student in a college or university? ❍ Yes ❍ No

If "Yes", please indicate the name of the college or university and provide copy of a certificate or affidavit from the college or university as evidence of full-time student status. _____

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

[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**.

❷ PRODUCT, PLAN AND ADDITIONAL COVERAGE REQUESTED

Bupa Care Suite: Diamond Care: ❍ Worldwide ❍ Latin America Only[2] Complete Care: ❍ Worldwide ❍ Latin America Only[2]

Deductible Plan:	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6
In-country	0	1,000	2,000	5,000	10,000	20,000
Out-of-country	1,000	2,000	3,000	5,000	10,000	20,000

Renewals/additions: ❍ P1 Diamond ❍ P1 Gold ❍ P1 Gold LA ❍ P1 Silver ❍ Silver ❍ Premier Care Deductible: _____

Requested effective date of coverage: / / (Month Day Year)

Additional coverage: If no additional coverage is selected, none will be granted.
❍ Complications of maternity[3] ❍ Other: _____

[2] Excludes Mexico [3] Please fill out a Maternity Questionnaire

❸ OTHER INSURANCE INFORMATION

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

Company name: _____ Tel. No.: _____

Product name: _____ Deductible value: _____ Policy No.: _____

(3.2) Do you intend to keep your insurance coverage with the other company? ❍ Yes ❍ 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? ❍ Yes ❍ No

If "Yes", please explain: _____

❹ GENERAL INFORMATION

(4.1) Address

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

(4.2) 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

(4.3) Telephone, fax and e-mail

Home	Country code	Area code	Number	Work	Country code	Area code	Number
Fax	Country code	Area code	Number	Cell	Country code	Area code	Number
E-mail							

❺ BENEFICIARY INFORMATION

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

❻ MEDICAL INFORMATION

(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
Applicant's name	Doctor's name
Specialty	Telephone

(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.

Applicant	Type of exam	Date
		/ / Month Day Year

Result	If abnormal, please describe.
❍ Normal ❍ Abnormal	

❻ MEDICAL INFORMATION (continued)

Applicant	Type of exam	Date
		/ / Month Day Year

Result	If abnormal, please describe.
❍ Normal ❍ Abnormal	

Applicant	Type of exam	Date
		/ / Month Day Year

Result	If abnormal, please describe.
❍ Normal ❍ Abnormal	

Applicant	Type of exam	Date
		/ / Month Day Year

Result	If abnormal, please describe.
❍ Normal ❍ Abnormal	

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 conditions

	Has any applicant ever had …	Yes	No
a	infections?	❍	❍
b	vision, ear, hearing, nose, or throat disorders?	❍	❍
c	seizures, migraine, paralysis, or other neurological disorders?	❍	❍
d	heart disorders, circulatory disorders, high blood pressure, high cholesterol, or high triglycerides?	❍	❍
e	allergies, asthma, bronchitis, or other pulmonary disorders?	❍	❍
f	esophagus, stomach, intestines or pancreas diseases, hepatitis, other liver diseases or digestive disorders?	❍	❍
g	kidney or urinary tract diseases?	❍	❍
h	spinal column problems, rheumatism, arthritis, gout, or other muscle, joint or bone disorders?	❍	❍
i	cancer or benign tumors?	❍	❍
j	anemia, leukemia/lymphoma or other blood disorders?	❍	❍
k	diabetes, thyroid gland disorders or other endocrine/hormonal disorders?	❍	❍
l	prostate disorders?	❍	❍
m	sexually transmitted or sexual organs diseases, or other reproductive disorders?	❍	❍
n	breast, ovaries/uterus disorders, or other gynecological disorders?	❍	❍
o	skin disorders?	❍	❍
p	congenital or hereditary disorders?	❍	❍
q	any other disease, disorder, illness, injury, accident, surgery, pending surgery, or hospitalization **not mentioned before?**	❍	❍

(6.4) Medical conditions/explanations

Letter	Applicant	Condition

From	To	Treatment and results
/ / Month Day Year	/ / Month Day Year	

Current state of health	Doctor's information

Letter	Applicant	Condition

From	To	Treatment and results
/ / Month Day Year	/ / Month Day Year	

Current state of health	Doctor's information

Letter	Applicant	Condition

From	To	Treatment and results
/ / Month Day Year	/ / Month Day Year	

Current state of health	Doctor's information

❻ MEDICAL INFORMATION (continued)

Letter	Applicant	Condition

From	To	Treatment and results
/ / Month Day Year	/ / Month Day Year	

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. ❍

(6.5) 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	To
		/ / Month Day Year	/ / Month Day Year

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

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

Applicant	Name of medication		Amount
Reason	Frequency	From	To
		/ / Month Day Year	/ / 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/day
Applicant	Type	How long?	Amount/day
Applicant	Type	How long?	Amount/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	
	❍	❍	❍	❍	
	❍	❍	❍	❍	
	❍	❍	❍	❍	

❼ PAPERLESS CUSTOMER SIGN UP

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

❽ ACKNOWLEDGEMENT AND AUTHORIZATIONS

Declaration

Claims and other benefits may not be payable if you do not fully disclose any material fact which could influence our assessment and acceptance of this application, and if there is any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters.

If your health changes after the application has been signed but before Bupa Insurance Limited (Bupa) has approved the insurance, you must notify Bupa immediately of such change. You may be required to provide Bupa with medical reports in relation to this and any other pre-existing conditions.

In view of the following declaration, it is essential that complete information is supplied.

I declare that to the best of my knowledge and belief the information given by me is true and complete, and that, apart from the conditions fully disclosed to Bupa, I and any dependents under 18 to be insured on my policy are in excellent health and do not suffer or have suffered from any recurring illness or physical debility. If insurance for dental treatment is required, neither myself nor my dependents are under or about to undergo dental treatment.

I declare on my behalf and on my dependents' behalf, that I have read the policy conditions and this section of the Individual Health Insurance Application, and accept that the policy conditions together with the certificate of coverage and the Individual Health Insurance Application will represent the insurance contract with Bupa. I also declare that neither I nor my dependents under 18 are residents of the United States of America.

I confirm on my behalf and on my dependents' behalf, that I have read the Data protection notice below, and give explicit consent for Bupa to use my personal information and that of my dependents under the age of 18 in the manner and for the purposes stated.

Data protection notice

Purpose: Personal data collected about you and your dependents will be used by Bupa Insurance Limited (Bupa) to process your claims, collect premium, provide reimbursements, administer your policy, and to detect and prevent fraud or improper claims. If Bupa does not accept your application, your information may be recorded by us.

Confidentiality: Bupa complies with applicable data protection legislation and medical confidentiality guidelines. All correspondence concerning your policy will be sent to the policyholder and/or the intermediary. All insured persons on the policy may have access to correspondence and other information sent by Bupa or accessed at www.bupalatinamerica.com. Bupa uses third parties to process data on its behalf, and your data may be processed in or outside the European Economic Area (EEA). Bupa may exchange your information within the Bupa group and with your intermediary.

Medical information: Bupa may seek and exchange information about you and your dependents' health and treatment with those involved in your and your dependents' care (including your treating doctor and hospital) and their agents, and if applicable, any person or organization who may be responsible for meeting your and your dependents' treatment expenses, or their agents, as deems necessary.

Telephone calls: In the interest of continuously improving our service to customers, your call will be recorded and may be monitored.

Research: Aggregated data and data which has been made anonymous, may be used by Bupa, or disclosed to others, for research or statistical purposes.

Fraud: Information, including recorded telephone calls, may be disclosed to others with a view to preventing or detecting fraudulent or improper claims.

Names and addresses: Bupa does not make the names and addresses of customers available to other organizations (except as stated above).

Keeping you informed: Bupa would, on occasion, like to keep you informed of its products and services which it considers may be of interest to you. Data protection legislation gives you the right to see documents and information Bupa has recorded about you.

Contact address: If you do not wish to receive information about our products and services, or would like to see a copy of the information we hold about you, please write to the Bupa group Head of Information Governance at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, England or at DataProtection@bupa.com.

Authorization to collect health information

I hereby authorize Bupa Insurance Limited and its Miami subsidiaries and affiliates (collectively "Bupa") to request my and/or my dependents' medical records, any prescribed medication history, and any other medical or pharmaceutical information to be considered in the underwriting decision upon my and/or my dependents' application. I authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, the Medical Information Bureau (MIB), or any other organization or person, including any member of my family having any medical records or knowledge of myself or my health, to disclose such information to Bupa or its designated agents.

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa 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 Limited and its Miami subsidiaries and affiliates (collectively "Bupa") to 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 (HIPAA) regulation and that the disclosure of information will be done under the applicable HIPAA 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. 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
7001 S.W. 97th Avenue
Miami, Florida 33173 USA
Privacyoffice@bupalatinamerica.com

I (we) have reviewed and understand the content and purpose of the acknowledgement and authorizations. By signing or replying affirmatively, I (we) confirm that the authorization decisions noted above accurately reflect my (our) wishes. The signature(s) below constitute(s) acceptance of all items listed above. This application is valid for 90 days as of the date of signature. **All dependents 18 years or older must sign**.

❾ SIGNATURES

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

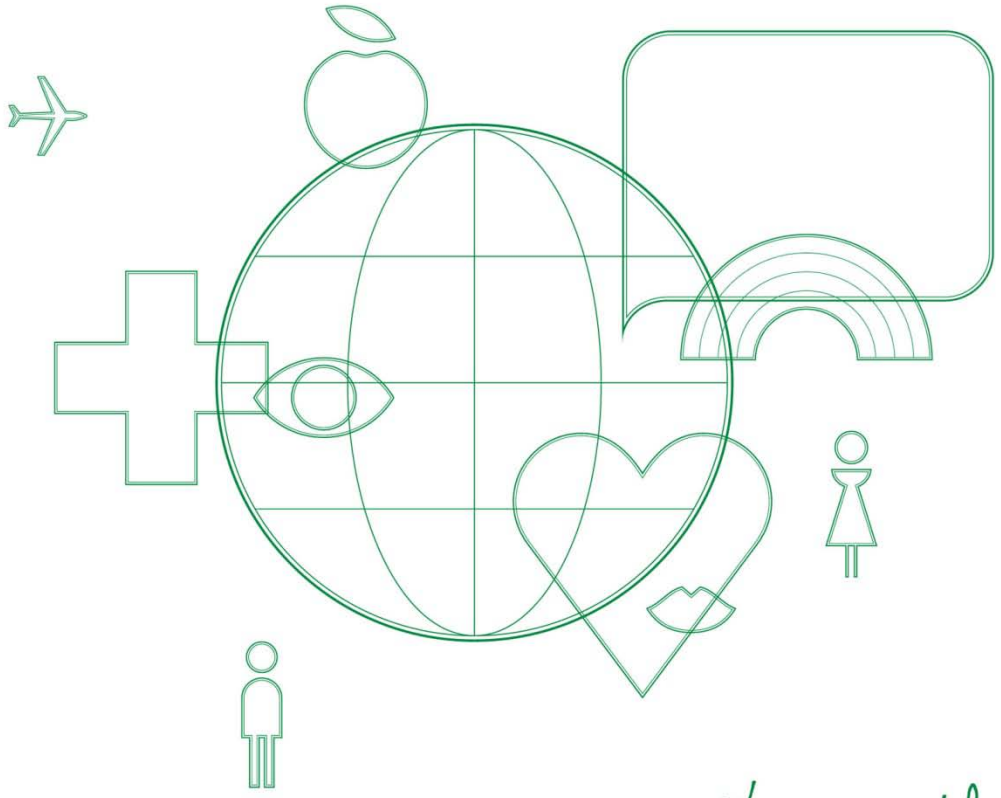
As Producer, I accept full responsibility for the submission of this application, for sending all the collected premiums, and for the delivery of the policy when issued. **I do not know of any condition that has not been disclosed in this application which will affect the insurability of the proposed insured(s).**

Producer's printed name	Producer's signature (witness)	Producer's code

Bupa Insurance Limited
Bupa House, 15-19 Bloomsbury Way
London WC1A 2BA, UK

Registered in England No. 3956433.
Bupa Insurance Limited is authorized
and regulated by the United Kingdom's
Financial Services Authority.

Administration:
7001 S.W. 97th Avenue
Miami, Florida 33173
Tel. +1 (305) 398 7400
Fax +1 (305) 275 8484
www.bupalatinamerica.com
bupa@bupalatinamerica.com



The world of Bupa

Bupa Diamond Care
Bupa Complete Care
Bupa Advantage Care
Bupa Secure Care
Bupa Essential Care
Bupa Critical Care
Bupa Corporate Care
Premier 1 Diamond
Premier 1 Gold
Premier 1 Silver
Silver
Premier Care

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

Policyholder's name	Policy No.

Policy type: ❍ Annual ❍ Semi-annual ❍ Quarterly

Premium: US$ _____
Optional coverage: US$ _____
Annual administrative fee: US$ 75.00
Total amount: US$ _____

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, Account #2000037371881, ABA #121000248, SWIFT #WFBIUS6S, CHIPS #30407

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: ❍ MasterCard ❍ VISA ❍ AMERICAN EXPRESS ❍ DINERS CLUB INTERNATIONAL

Credit card number: _____ Expiration date: ____/____ (Month / Year) CVC: _____

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 and/or bank 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 and/or banking 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)

Bupa Insurance Limited
Bupa House • 15-19 Bloomsbury Way • London WC1A 2BA, United Kingdom
Administration • 7001 S.W. 97th Avenue • Miami, Florida 33173
Tel. +1 (305) 398 7400 • Fax +1 (305) 275 8484 • www.bupalatinamerica.com • bupa@bupalatinamerica.com