Claria
LIFE AND HEALTH INSURANCE

APPLICATION

PAYMENT CYCLE

ANNUAL ◯ SEMIANNUAL ◯ QUARTERLY ◯ MONTHLY ◯

FORM OF PAYMENT

CHECK ◯ CREDIT CARD ◯ WIRE TRANSFER ◯

PLAN

◯ MUNDIAL OPTION 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ ◯ SKY ◯ SUN ◯ STAR

COVERAGE

◯ **$1,000,000** (SKY/SUN/STAR)
◯ **$2,000,000** (SKY)
◯ **$3,000,000** (MUNDIAL)

DEDUCTIBLE

$

1. APPLICANT INFORMATION

FIRST NAME	LAST NAME	RELATION PRIMARY	GENDER	DATE OF BIRTH *(DD/MM/YYYY)*	AGE	HEIGHT *(MTS/FT)*	WEIGHT *(LBS/KGS)*	NATIONALITY	PREMIUM

FILING STATUS (PRIMARY) Single ◯ Married ◯ Divorced ◯ Widower ◯

INCLUDE COPY OF PICTURE ID FOR THE MAIN INSURED

IF SPOUSE AND/OR CHILDREN ARE NOT INCLUDED IN THE APPLICATION EXPLAIN WHY:

2. OPTIONAL COVERAGE

◯ SINGLE MOTHER MATERNITY + $300 (OPTIONAL SKY)

◯ STUDENT IN THE UNITED STATES +$375

◯ AD&D COVERAGE (OPTIONAL FOR SKY, SUN & STAR, AN ADDITIONAL CHARGE OF $18 WILL BE ADDED TO YOUR PREMIUM FOR EVERY $10,000 OF COVERAGE UP TO $100,000)

PRIMARY
COVERAGE $ **ADDITIONAL CHARGE $**

SPOUSE
COVERAGE $ **ADDITIONAL CHARGE $**

3. PREMIUMS

ANNUAL PREMIUM	PREMIUM FACTOR	ADMINISTRATIVE COST	TOTAL PREMIUM
$	**SEMIANNUAL: x 0.55** **QUARTERLY: x 0.28** **MONTHLY: x 0.10**	**$100.00**	

4. PERMANENT RESIDENCE ADDRESS (CANNOT BE A UNITED STATES ADDRESS)

ADDRESS: _____

CITY: _____ COUNTRY: _____

TEL: _____ CEL: _____ EMAIL: _____

5. EMPLOYERS NAME AND ADDRESS

NAME: _____ NATURE OF BUSINESS: _____

ADDRESS: _____

CITY: _____ COUNTRY: _____ WEBSITE: _____

TEL: _____ CEL: _____ EMAIL: _____

6. OCCUPATION AND DUTIES

PRIMARY: _____ TITLE: _____

LIST SPECIFIC DUTIES: _____

SPOUSE: _____ TITLE: _____

LIST SPECIFIC DUTIES: _____

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7. UNDERWRITING QUESTIONS FOR ALL APPLICANTS

For your application to be processed successfully each question must be answered truthfully.
Any affirmative (Yes) must be described in detail in Section 8.
Applicants over 59 must submit an Attending Physician Statement (APS).

During the past ten (10) years, have you or any applicant been: medically advised, referred, advised, had surgery, treated, diagnosed or taken medication prescribed for a condition, included but not limited to any of the conditions listed below?

"Section 7: Details of Medical History." Attach medical information or reports for each question answered affirmatively. All questions for all applicants must be answered with complete information including all supporting medical records.

		YES	NO
1	Cardiovascular or circulatory diseases: high/low blood pressure, chest pain, heart murmur, palpitations, pacemaker or any disorder or condition of the heart	☐	☐
2	Cell or blood related disorders: benign / malignant tumors, cancer, varicose veins, swollen lymph nodes, rheumatic fever or any circulatory disorder	☐	☐
3	Diseases or disorders of the musculoskeletal system: back pain, pain in joints / muscles, fibromyalgia, rheumatism, arthritis, gout any musculoskeletal disorder or condition	☐	☐
4	Diseases or disorders of the digestive system, esophagus, stomach, intestines, pancreas, liver, gallbladder: ulcers, gastritis, polyps, hemorrhoids, colitis or any gastrointestinal disorder or condition	☐	☐
5	Diseases or disorders of the nervous system or neurological disorders: migraine, severe/ frequent headaches, frequent / severe epilepsy, seizures or any neurological disorder or disorder of the nervous system	☐	☐
6	Diseases or disorders of the kidney or urinary system: blood in urine, urinary infections, incontinence, or any disorder or condition of the kidney or urinary system	☐	☐
7	Pulmonary or Respiratory diseases or disorders: asthma, allergies, emphysema, pneumonia, tuberculosis or any disorder or condition of the respiratory system?	☐	☐
8	Diseases or disorders of the eyes, nose, ears and throat	☐	☐
9	Congenital, genetic or hereditary diseases or disorders: physical impairment, deformity or developmental problem	☐	☐
10	Addictive or mental diseases or disorders: attention deficit disorder, depression, anxiety, bipolar disorder, eating disorder	☐	☐
11	Hormonal or endocrine diseases or disorders: thyroid, pituitary gland or any condition or disorder of the endocrine system.	☐	☐
12	Diabetes **a.)** _____Type I Type II _____ **b.)** Date of initial diagnosis_____ **c.)** Drugs: _____dose _____	☐	☐
13	Sexually transmitted diseases or immune deficiency disorder, AIDS or HIV	☐	☐
14	Any type of skin diseases or disorders	☐	☐
15	Cosmetic Surgery, oral surgery, dental condition, infection or treatment of weight loss	☐	☐
16	Any other diseases or disorders	☐	☐
17	Have you or any applicant consulted a therapist or physician, had surgery, been hospitalized or is there any reason why you should visit a doctor or been advised for the need to be hospitalized	☐	☐
18	Have you or any applicant been advised to have any kind of diagnostic test, undergone special testing including but not limited to: (x-rays, electrocardiogram, radiology or any blood work)	☐	☐
19	Have you been advised or are taking any prescription drug or is there some reason why you should be taking a medication	☐	☐
20	Are you currently hospitalized or suffering from illness, disability or unable to perform normal activities	☐	☐
21	Have you experienced any symptoms, had any physical changes that are visible, been diagnosed, treated or is there any reason that makes you think you may have a new medical condition?	☐	☐
22	Have you or any applicant used some form of tobacco? Quantity _____ Frequency _____	☐	☐
23	For male applicants: diseases of the prostate or reproductive system	☐	☐
24	For female applicants:		
	• Diseases of the reproductive system	☐	☐
	• Are you currently pregnant? Due date ____ / ____ / ____	☐	☐
	• Do you currently have or have ever had pregnancies or births in which you manifested: hypertension, diabetes, thyroid disorders, infections or were prescribed medications?	☐	☐
	• Do you have or have had complicated pregnancies or deliveries?	☐	☐
	• Have you undergone or are currently undergoing fertility treatments?	☐	☐
	• Have any of your children been conceived with fertility treatment?	☐	☐
25	Have you or any other applicant:		
	• Tested positive for Coronavirus / COVID-19 or are you awaiting the results of the test?	☐	☐
	• Had contact with a Coronavirus / COVID-19 carrier patient or someone you suspect of having been in contact with Coronavirus / COVID-19 patients?	☐	☐
	• Had general symptoms such as fever, muscle pain, weakness, headache, shortness of breath, or respiratory symptoms such as a sore throat, cough, or runny nose in the past 30 days?	☐	☐
26	Are there any additional documents attached to the application? if the answer is "yes", please detail below.	☐	☐

_____

_____

_____

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8. HEALTH HISTORY DETAILS

GIVE FULL DETAILS FOR EACH APPLICANT ON AFFIRMATIVE ANSWERS IN SECTION 7
(USE ADDITIONAL PAPER AND ATTACH MEDICAL REPORTS FOR CORRESPONDING QUESTIONS IF NECESSARY).
INCOMPLETE ANSWERS MAY DELAY PROCESSING.

NAME	QUESTION #	CONDITION, DIAGNOSIS, TREATMENT, MEDICATION PRESCRIBED AND RESULTS OF TREATMENT	DATE SEEN AND DURATION	ADDRESS AND PHONE # PHYSICIAN HOSPITAL

9. PROVIDE NAME, ADDRESS AND PHONE NUMBER OF APPLICANTS' FAMILY PHYSICIAN OR PHYSICIAN WHO PERFORMED LAST ROUTINE PHYSICAL. (WITHOUT THIS INFORMATION THIS APPLICATION WILL NOT BE PROCESSED)

PRIMARY INSURED: _____ LAST VISIT DATE: _____

NAME OF PHYSICIAN: _____ REASON: _____

CITY/COUNTRY: _____ TEL: _____ EMAIL: _____

SPOUSE: _____ LAST VISIT DATE: _____

NAME OF PHYSICIAN: _____ REASON: _____

CITY/COUNTRY: _____ TEL: _____ EMAIL: _____

CHILDREN: _____ LAST VISIT DATE: _____

NAME OF PHYSICIAN: _____ REASON: _____

CITY/COUNTRY: _____ TEL: _____ EMAIL: _____

10. LIST OF ELIGIBLE FULL TIME STUDENTS BETWEEN THE AGE OF 18 TO 23 (PROOF OF STUDENT STATUS IS REQUIRED)

STUDENT NAME	COLLEGE/UNIVERSITY-LOCATION

11. PRIOR OR CURRENT HEALTH INSURANCE COVERAGE

YES ◯ NO ◯ LIST ALL CURRENT OR PRIOR HEALTH INSURANCE _____

11A LOCAL HEALTH INSURANCE

INSURANCE COMPANY: _____ POLICY NUMBER: _____

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

11B INTERNATIONAL HEALTH INSURANCE

INSURANCE COMPANY: _____ POLICY NUMBER: _____

EFFECTIVE DATE: _____ EXPIRATION DATE: _____

11C HAVE YOU OR ANY APPLICANT BEEN DECLINED, APPLIED AN EXCLUSION, OR HAD A RATE UP IN PREMIUM WITH ANY OTHER HEALTH, DISABILITY OR LIFE POLICY? ► YES ◯ NO ◯

11D HAS ANY CLAIM BEEN PRESENTED FOR COVERAGE OF BENEFITS UNDER ANY INSURANCE POLICY BY YOURSELF OR ANY OF THE PROPOSED INSURED? ► YES ◯ NO ◯

GIVE DETAILS TO AFFIRMATIVE ANSWERS: _____

12. DECLARATION AND ENROLLMENT REQUEST/ AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I CERTIFY that I have read and reviewed the completed application and all the answers and statements I provided on this Application and any attachment which I checked and itemized in section 7 question 25 page 2 hereto is complete truthful to the best of my knowledge and belief. If I did not mark with a "yes" section 7 question 25 on page 2, I understand that no additional information was submitted with this application. All information and answers about all applicants including my eligible dependents listed in this application are true and complete. I understand that the Administrator, Global Assurance Group and Claria Life and Health Insurance Company will rely on all information in this Application in determining whether or not to issue coverage and that any omissions, incorrect or incomplete information will cause claims to be denied and the policy to be modified, cancelled or rescinded at any time upon discovery regardless if the omission, incorrect or incomplete information is related to a claim at hand or not.

I UNDERSTAND that the insurance agent, broker or producer, if any, involved with the respect to the solicitation of the application is located and is transacting his services outside the United States and is solely acting as my legal agent and representing my personal interests and as such has no authority to bind, receive payment to his name or his company name and is not acting as the legal agent or representative of the Company.

I UNDERSTAND that this application seeks full disclosure of the information sought and no one has the authorization to alter or exclude any information sought in this application.

I UNDERSTAND that health benefits may be limited or excluded for conditions which any insured person has received any medical diagnosis or treatment, or taken any medication, before his or her effective date, according to pre-existing conditions limitations provisions of the plan. If any person requires medical care or treatment after the application for insurance is signed, and before the effective date of this policy, full details must be provided to the insurer for final approval before coverage is effective. I agree to accept the policy with the terms and conditions as issued, otherwise I will notify my disagreement in writing to the company within the first ten (10) days of receipt of the insurance policy.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, Insurance or reinsuring company, employer or any individual having any information about me or my dependents listed on this application to disclose to Global Assurance Group and Claria Life and Health Insurance Company, or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to any information about: 1.) physical condition(s), 2.) health history(ies), 3.) avocations, 4.) age(s), 5.) occupation(s), and 6.) personal characteristics. This authorization includes information about: 1.)drugs, 2.) alcoholism, 3.)mental illness, or communicable diseases. A photocopy of this application shall be valid as the original. This authorization shall remain valid as long as any insurance is in force.

I UNDERSTAND that the information obtained by use of this Authorization will be used by Global Assurance Group and Claria Life and Health Insurance Company to determine eligibility for benefits.

I AUTHORIZE, Global Assurance Group and Claria Life and Health Insurance Company to release any information obtained to reinsuring companies, Medical Information Bureau Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize.

I AGREE that the rules of Claria International Health Plans will be binding on me and all eligible dependents included in my policy. You are advised to keep record of all information you supply to us in connection with this application, including letters. If you would like a copy of this form please inform us.

I UNDERSTAND that I am purchasing this policy as a resident of a foreign jurisdiction outside the United States I may be subject to foreign laws with the respect to the type and form of the coverage in which I am enrolling.

I UNDERSTAND that the Application is valid for underwriting for a maximum of 90 days. If the Administrator does not 1. approve policy and 2. receive any pending rider signed and 3. receive premium payment at the Administrator's office within the 90 days, application will be void and a new application must be submitted for new underwriting.

I UNDERSTAND that the policy will become effective in accordance with the terms of the effective date and the acceptance of, Global Assurance Group, and Claria Life and Health Insurance Company. I understand that no coverage is in effect until I am notified in writing by Global Assurance Group and Claria Life and Health Insurance Company and advised of the official Effective Date. I also understand that if I am not accepted for coverage by Global Assurance Group and Claria Life and Health Insurance Company, it is the sole obligation of Global Assurance Group, and Claria Life and Health Insurance Company to return the premium paid.

I UNDERSTAND that this coverage is not, nor does it intend to be a United States health insurance policy. I understand that it can not be solicited, applied for or purchased in the United States. I understand that if this application and policy is solicited and/or, applied for and/or purchased and/or renewed while in the United States that this policy will be automatically canceled and voided from inception and premiums returned. I understand that the coverage in the United States is limited to six (6) months out of the twelve (12) months policy period. If I or any applicant spends more than the allotted six (6) months out of the twelve (12) months policy period in the United States this coverage will be voided and all claims from the void date will not be paid.

I UNDERSTAND that all information I know that is responsive to all questions in this application must be provided in my answers. I understand and agree that any omissions, incorrect or incomplete information may constitute an act of fraud against the insurance company.

This Insurance is not subject to, and does not provide certain of the insurance benefits required by, the United States' Patient Protection and Affordable Care Act ("ACA"). This insurance does not provide, and insurers do not intend to provide, minimum essential coverage under ACA. In no event will benefits be provided in excess of those specified in the contract documents. This insurance is not subject to guaranteed issuance or renewability other than as specified in the policy. ACA requires certain US citizens and US residents to obtain ACA compliant health insurance coverage. In some circumstances penalties may be imposed on person or persons who do not maintain ACA compliant coverage. Each Insured Person should consult their attorney or tax professional to determine if ACA's requirements are applicable to him/her.

THIS APPLICATION WILL BE NULL AND VOID IF SIGNED IN THE UNITED STATES.

SIGNATURE OF THE PROPOSED INSURED OR GUARDIAN

SIGNATURE OF PROPOSED INSURED'S SPOUSE

COMPLETE NAME

COMPLETE NAME

SIGNED ON _____ **OF** _____ **, 20** _____ **, IN THE CITY OF** _____ **, COUNTRY** _____

13. AGENT INFORMATION (FOR AGENT USE ONLY)

AGENT CERTIFICATION: I AM NOT AWARE OF ANY OTHER INFORMATION WHICH MAY HAVE A BEARING ON THE INSURABILITY OF ANYONE TO BE COVERED AND I HAVE NOT ALTERED ANY RESPONSES RECORDED ON THIS APPLICATION OR ANY SUPPLEMENT TO IT. I HAVE NOT ADVISED THE APPLICANTS TO WITHHOLD ANY INFORMATION RELATED TO THE ANSWERS TO THE QUESTIONS AND I HAVE ADVISED THE APPLICANTS TO REVIEW THE APPLICATION AND THE ANSWERS RECORDED TO CONFIRM THEIR COMPLETENESS AND ACCURACY.

SUB-AGENT CODE

NAME OF SUB-AGENT

AGENT CODE

NAME OF AGENT

GENERAL AGENT CODE

NAME OF GENERAL AGENT

GENERAL AGENCY CODE

NAME OF GENERAL AGENCY

AGENT SIGNATURE

14. ACKNOWLEDGMENT OF APPROVAL TO POLICY OF INSURANCE

I UNDERSTAND that the Administrator, Global Assurance Group, and Claria Life and Health Insurance Company, will rely on all information on Application submitted in determining whether or not to issue coverage and that any omissions, incorrect or incomplete information will cause claim/s to be denied and the policy to be modified, or rescinded retroactively from issue date at any time upon discovery.

I UNDERSTAND that Administrator, Global Assurance Group, and Claria Life and Health Insurance Company seek full disclosure of the information sought in this application and no one has the authorization to alter or exclude any qualification information sought in this application.

I UNDERSTAND that the approval for cover with CLARIA is based on the questionnaire completed on the application and will be subject to medical records received.

I UNDERSTAND that if any medical conditions are detected before or after approval and before policy is paid and any rider signed will result in modifications or cancellation of coverage terms at the administrator discretion.

"Pre-Existing Condition" shall mean any one or more or of the following 1) A condition or symptom that would have caused a person to seek medical advice, diagnosis, care or Treatment prior to the Individual Effective Date of Coverage under this Certificate; 2) A condition for which medical advice, diagnosis, care or Treatment, including Medication, was sought, recommended or received prior to the Individual Effective Date of Coverage under this Certificate; 3) the symptoms which occurred prior to the Individual Effective Date of the Coverage under this Certificate would have allowed a person trained in medicine to make a diagnosis of the condition producing the symptoms: 4) a condition which manifested prior to the Individual Effective Date of Coverage under this Certificate; 5) Expenses for Pregnancy including pre, post, birth, birth complications to the mother or the newborn within twelve (12) months after the Individual Effective Date of Coverage under this Certificate.

Representations in Application: Any statement or description made by or on behalf of the Insured Person on the Application for Insurance Coverage is a representation and is not a warranty. A misrepresentation, omission, concealment of fact, or incorrect statement may prevent recovery under the Certificate if either of the following apply; a.) the misrepresentation, omission, concealment of fact, or statement is false and/or fraudulent, whether material or not to the approval of the Coverage for the Insured Person, or b.) if the facts had been known to the Administrator or Company prior to issuance of Coverage, the Administrator or Company would not have issued Coverage, would not have issued Coverage at the same Premium or would have issued an Exclusionary Rider to the Coverage under this Certificate.

When a misrepresentation, omission, concealment of fact, or incorrect statement occurs on the application or accompanying health statements, regardless whether the misrepresentation, omission, concealment of fact, or incorrect statement is related to a possible claim at hand or not, the company at their discretion may choose to either rescind and void the certificate and return all the premium to the payer retroactive to the original Individual Effective Date of Coverage or issue a permanent exclusion for a particular pre-existing condition and deny the claim. In the case that a policy is rescinded any claim payments made on the policy from the Effective date until the date the policy is rescinded will be applied towards the return of premium which is retroactive to the Effective Date.

In the case that the administrator decides to apply a pre existing condition exclusion to the policy any past payment amount made towards a claim that was found to be due to a Pre Existing Condition will be added to the Insured's future renewal premium. Insured will need to pay his renewal premium plus any past payment made by the insurance company for a pre existing condition in order to renew his policy.

SIGNATURE OF THE PROPOSED INSURED OR GUARDIAN

COMPLETE NAME

DATE AND TIME FOR INTERVIEW

ALTERNATE TELEPHONE NUMBER

SIGNATURE OF PROPOSED INSURED'S SPOUSE

COMPLETE NAME

TELEPHONE NUMBER: