



GLOBAL BENEFITS GROUP

Insurance Without Borders®

26000 Towne Centre Drive, Suite 100, Foothill Ranch, CA 92610 USA

Phone: +1.949.470.2100 Fax: +1.949.470.2110 E-mail: info@gbgi.net



## International Select Health Insurance Application

### A. Instructions

1. Please **print** or **type**. Read all the agreement terms carefully and complete all sections. If the space provided is insufficient, please attach additional sheet(s) of paper. **Sign** the application.
2. Enter the name of only those family members currently eligible.
3. Enclose payment with the application.
4. All check payments should be made payable to: GBG Holdings, Inc.
5. Return application to address shown at the top of this application.

### B. Policy Format Preference

Please indicate whether you wish to receive your policy (Contract) information in Hardcopy or Electronic Format (Website download).

- Hardcopy** (Paper)                       **Electronic Format** (Website download)

### C. Coverage Selection Information

Insurance Coverage Selected for:  Self  Spouse  Children How many children? **Policy #** \_\_\_\_\_  Add Dependent

#### Major Medical Health Insurance

**Plan** (choose one)                       International Select Gold                       International Select Silver (emergency only in US & Canada)

\$15,000                       \$20,000

**Deductible** (choose one)  \$500     \$1,000     \$2,000     \$2,500     \$4,000     \$5,000     \$10,000                       \$25,000

**Premium Payment Mode** (choose one)                       Annual                       Semi-Annual

**Major Medical Premium** (Based on Region Selected Above):.....\$ \_\_\_\_\_

#### Optional Riders

Dental (\$408 annual or \$210 semi-annual, per person).....\$ \_\_\_\_\_

Accidental Death (\$48 annual or \$24 semi-annual, per adult; \$12 annual or \$6 semi-annual, per child).....\$ \_\_\_\_\_

#### Other Insurance Plans (Separate Policies)

Critical Illness (select one deductible)     \$1,000     \$5,000                       \$10,000                       \$25,000                       \$50,000

**Critical Illness Premium:** .....\$ \_\_\_\_\_

Hospital Cash (select one daily benefit amount)                       \$50     \$75     \$100     \$125                       \$150                       \$175                       \$200

Accident and Illness

**Hospital Cash Premium:** .....\$ \_\_\_\_\_

**TOTAL PREMIUM:** \$ \_\_\_\_\_

**D. Personal Information (primary insured)**

Name: \_\_\_\_\_  
Last Name First Name Middle Name Jr., Sr.

**Residential Address:**

Street and Number \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

**Mailing Address** (if different from above):

Street and Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_ Zip Code \_\_\_\_\_

Male  Married  Divorced  Active Employee  Retired  
 Female  Single  Widowed  Fulltime Student  Self-Employed

**E. Employment Status**

Company/School Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street and Number

City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Position: \_\_\_\_\_ Years there: \_\_\_\_\_ Are you a frequent traveler?  Yes  No

Please complete the information below for both you and your dependents. (Attach another page for additional Dependents if necessary)

Print full name of applicant and other members of family.	Nationality	Passport Number	Relationship to Applicant	Sex: M / F	Date of Birth MM/DD/YY	Age	Height Ft., In.	Weight Lbs.

**F. Other Health Care Coverage**

Do you (or any dependents listed on this application) have other medical insurance coverage?  Yes  No

If Yes, provide name of other medical insurance company: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Who is insured?  Yourself  Spouse  Dependent Children

Policy Number: \_\_\_\_\_

Are you applying for the GBG coverage indicated in Section C in order to replace another sickness and accident or other health policy that you presently have in effect?  Yes  No

Are you currently applying for or currently contemplating applying for, health insurance with another insurance company which could result in the issuance of a policy on the same date or the approximate same date as that of GBG.  Yes  No

If Yes, please provide the name of the other insurance company and date of application: \_\_\_\_\_

**G. Health Related Information.** False or incomplete information will void health coverage.

1. Do you (or any dependents listed on this application) have a family physician?  Yes  No If Yes, complete "a", below.

a. Names and complete addresses of your family physicians: \_\_\_\_\_

2. Is each person for whom application is being made in good health and without any known need for hospital or medical care?  
 Yes  No If No, provide details:

Name of person(s): \_\_\_\_\_

Type of illness: \_\_\_\_\_ Date(s) of treatment: \_\_\_\_\_

Names and phone, fax and e-mail address of attending physicians: \_\_\_\_\_

**Please provide a full explanation of any condition checked below.** (Attach separate sheet(s) of paper if necessary)

3. Do you (or any person applying for this coverage) have, or have you (or any person applying for this coverage) ever had, been treated for, or experienced symptoms of:

a. Tuberculosis, asthma, allergies, disease of lungs, respiratory system, shortness of breath, wheezing, blood-tinged sputum?.....  Yes  No

b. Diseases of the heart, cardiac, cardiovascular, chest pain or pressure, circulatory condition?.....  Yes  No

c. Blood vessels, arteries, blood pressure, dizziness/vertigo, numbness or tingling of extremities? (If yes, provide most recent blood pressure reading and a Hypertension Questionnaire).....  Yes  No

d. Cancer, leukemia, cyst or tumor or any other growth (malignant or benign) or other disease and/or disorder of the blood, including anemia?.....  Yes  No

e. Disease of digestive system, stomach, liver, gall bladder, hemorrhoids, rectal trouble, chronic heartburn/indigestion, ulcer?.....  Yes  No

f. Paralysis, convulsions, disease of the brain or nervous system, Attention Deficit Disorder (ADD), chronic headaches, migraine headaches, double or blurred vision, weakness of any extremity? .....  Yes  No

g. Disease of urinary system, kidneys, ureters, bladder, prostate, urethra, frequent or painful urination, difficult urination or bloody urine?.....  Yes  No

h. Disorders of the back, knee or hip, joint surgery, arthritis, gout, diseases of the muscles, bones and joints, swollen/painful joints?.....  Yes  No

i. Any deformity, skin disorder, abnormal growth, spinal curvature, lameness, loss of limb, back disorder? .....  Yes  No

j. Hernia, rupture, venereal disease, diabetes (if yes, provide a Diabetes Questionnaire), thyroid, epilepsy, nervous or endocrine disorder?.....  Yes  No

k. Reproductive systems, including miscarriage, complications of pregnancy or delivery, any disorders of the breasts, uterus, ovaries, endometriosis, irregular or excessive menses, absence of menses?.....  Yes  No

l. Disorder of the immune system, Acquired Immune Deficiency Syndrome (AIDS) and/or AIDS-related complex (ARC)?....  Yes  No

m. Use of tobacco, alcohol or any habit-forming or recreational drugs? .....  Yes  No

n. Any illness, disease or physical impairment not mentioned in the questions above? .....  Yes  No

4. Have you (or any person applying for coverage) ever had counseling and/or treatment for a psychological or psychiatric condition? .....  Yes  No

5. Are you (or any person applying for coverage) taking any prescribed medication.....  Yes  No

6. Are any of the applicants pregnant? If Yes, please complete information below.....  Yes  No

7. Has any person applying for coverage consulted, been treated by any physician or practitioner, had an operation or been a patient in a hospital or similar institution for a condition other than those named in #3, above? If Yes, please complete the following:.....  Yes  No

Individual's Name	Complete Diagnosis / Condition	Date of Treatment MM /DD/YY	Types of Treatment Present Course of Treatment	Physician / Hospital / Clinic / Health Provider's Name(s), Address & Telephone

**H. Method of Payment (check one)**  VISA  MasterCard  American Express  Discover

Check payable to: *GBG Holdings, Inc.*

**Credit Card Billing Address: (must provide complete credit card billing address details in order to process)** My signature authorizes GBG Insurance Company to charge my International Health Coverage premium to the credit card account noted above and in the amount indicated by me. A 4 % annual surcharge has been factored into the semi-Annual Premium

Address \_\_\_\_\_ City \_\_\_\_\_

State/Providence \_\_\_\_\_ Postal \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_ 3 Digit Security Code: \_\_\_\_\_ (Last 3 digits\* on the back of the credit card)  
\* 4 digits for AMEX – front of Card

Amount: \$ \_\_\_\_\_

Print Name (as it appears on credit card): \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

**I. Conditions of Coverage. I understand and agree that:**

1. All applications are subject to acceptance and approval by GBG (*the Company*). The Company will determine eligibility after it receives my application with payment and any necessary medical records or documentation. If GBG approves my application, the Company will notify me of the effective date of my coverage.
2. All representations and information supplied by me are true, complete and correct and are given to induce the issuance of the Contract. The Contract will be void if any statement or representation made herein is false or incomplete.
3. All terms and conditions of this coverage are specified in the GBG International Health Insurance Contract, which shall be issued to me upon approval of the application. The application and all representations and statements made herein will be considered a part of the Contract.
4. I understand that GBG may need medical information to determine eligibility for coverage and benefits. I authorize any hospital, skilled nursing facility, health maintenance organization, pharmacy, physician, dentist, pharmacists, professional review organization and any and all other providers of service to disclose and furnish to GBG any and all records relating to the Insureds, including a complete diagnosis and all medical information for as long as the policy is in effect.
5. I authorize GBG to furnish to any Utilization Review Organization or to any other insurer or administrator, or to any health maintenance organization, or to any law enforcement agency, any and all medical records and information relating to the Insureds as deemed necessary by GBG for the administration of coverage.

**Application Disclaimer**

This GBG policy is an international health insurance policy. As such, the applicant should be aware that laws governing the terms, conditions, benefits and limitations in health insurance policies issued for delivery in the United States are not applicable to this policy. The applicant should further be aware that residency in the United States is grounds for declination of this application and grounds for cancellation of the policy once issued. The policy shall not become a contract binding on GBG or the applicant until the premium is paid and the policy is delivered to, and accepted by, the applicant either: i) physically by post, mail, courier, hand delivery or otherwise at the applicant's residence outside the United States; or ii) electronically through access to the GBG website and only after the applicant has, upon such access, acknowledged that he has accepted electronic delivery of the policy at a location outside the United States.

**Signature of  Applicant or  Legal Representative**

\_\_\_\_\_  
(on behalf of him/herself and all others applying for coverage)

\_\_\_\_\_  
Date

**J. Broker Information**

**I am submitting this application as Broker for the insured applying for coverage. I accept full responsibility for remitting all collected premiums and for the delivery of the policy to the insured when and if issued. I do not know of any physical, moral or employment problem not listed in this application.**

Premium:  Annual  Semi-Annual \$ \_\_\_\_\_

Make check payable to: *GBG Holdings, Inc.*

Producing Broker's Name (Print): DSI

Broker #: TBD

Producing Broker's Signature: Danone Simpson

Date: \_\_\_\_\_

Master Broker's Name (Print): DSI

Master Broker's #: TBD