



Please submit this form and all related correspondent to:

WEA Administrators

2525 Embassy Drive, Suite 15
Cooper City, FL 33026 - USA

Phone 1 (954) 889-2100
Fax 1 (954) 241-2002
Email info@wwexpa.com
URL www.weadirect.com

I, hereby declare
that there has been no change in the condition of my health, or the health of any family member applying for
coverage, since the date of my original application. I further declare that since the date of my original
application, neither I or any family member listed on the original application, have had any medical treatment
for any diagnosed condition not previously disclosed.

Applicant's Name	<input type="text"/>
Applicant's Signature	<input type="text"/>
Date (MM/DD/YY)	<input type="text"/>