



AAUG Insurance Company LTD

Please submit this form and all related correspondent to:

Worldwide Expatriate Association Ltd.

P.O. Box 4428, Columbus Centre
Road Town, Tortola, BVI

Toll Free 1 (800) 280-8478
Phone 1 (305) 390-0808
Email app-info@weadirect.com
URL www.weadirect.com

BENEFITS ARE PROVIDED THROUGH AND UNDERWRITTEN BY AAUG INSURANCE COMPANY.

A. INSTRUCTIONS

1. Please print or type. Read all agreement terms carefully and complete all sections. If space provided is insufficient, please attach additional sheet(s) of paper. **Sign** the application.
2. If you are signing for the applicant, please provide power of attorney documents with the application.
3. Enter the name of those family members currently eligible for coverage.
4. Enclose first payment with the application.
5. All payments should be made payable to: WEA.

B. PERSONAL INFORMATION

Applicant's Name (Last, First, MI) Nationality

Identification Number Date of Birth (MM/DD/YY) Male Female

Host Country Occupation

Claims Mailing Address: *This address will be used to send all policy documents and claims reimbursements.*

Street and Number

City State Country Postal Code

Home Phone Number E-mail Address

C. INSURED INFORMATION

Please complete all information below for you and your dependents. If there is not enough space provided, attach an additional page.

Print full name of individuals to be insured	Relationship	Nationality	ID Number	Sex: M/F	Date of Birth MM/DD/YY	Full Time Student	Height Ft. In.	Weight Lbs.

D. 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 Number

Who is insured? Yourself Spouse Dependent Children Policy Number

Are you applying for the WEA Global Plan in order to replace another sickness and accident or other health policy that you presently have in effect? Yes No

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Date Received (MM/DD/YY) Effective Date (MM/DD/YY) First Year Rates Spouse Number of Children

E. COVERAGE SELECTION INFORMATION

Requested Effective Date (MM/DD/YY)

Plan Option: CARE Option SELECT Option ELITE Option

Deductible Option: \$250 \$500 \$1,000 \$2,500 \$5,000

Area of Coverage Option: Worldwide Excluding the US

Optional Maternity Rider (2,500): Yes No

(Available on Care & Select options only, Elite option includes maternity benefits)

Life Insurance (optional):

All plans offer life and accidental death and disability coverage on the primary insured only. Please select from the face amounts:

Face Amount: \$10,000 \$25,000 \$50,000 \$75,000 \$100,000

Primary Beneficiary

Relationship

Secondary Beneficiary

Relationship

F. HEALTH RELATED INFORMATION (False or incomplete information will void health coverage)

If any of the following are answered as **NO**, please provide details in section **G**.

- | | Yes | No | |
|----|--------------------------|--------------------------|--|
| 1- | <input type="checkbox"/> | <input type="checkbox"/> | Do all dependent children live in your household? |
| 2- | <input type="checkbox"/> | <input type="checkbox"/> | Do all dependent children depend on you solely for support? |
| 3- | <input type="checkbox"/> | <input type="checkbox"/> | If any dependent child is age 19 or older, is/are they regularly attending school? |

If any of the following are answered as **YES**, please provide details in section **G**.

- | | Yes | No | |
|----|--------------------------|--------------------------|---|
| 4- | <input type="checkbox"/> | <input type="checkbox"/> | Is any individual pregnant? |
| 5- | <input type="checkbox"/> | <input type="checkbox"/> | Are there any inpatient or out patient medical or dental procedures (including diagnostic testing) recommended or contemplated? |
| 6- | <input type="checkbox"/> | <input type="checkbox"/> | Is any individual currently taking medication(s) for any condition? If "Yes," list individual(s), medication and dosage, and indicate duration of use and underlying condition. |
| 7- | <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco products? (If the include cigarettes, indicate packs per day <input type="text"/> and number of years smoked <input type="text"/> .) |

- | | Yes | No | <u>Within the Past</u> | <u>Has any Individual</u> |
|-----|--------------------------|--------------------------|------------------------|--|
| 8- | <input type="checkbox"/> | <input type="checkbox"/> | 5 years | Been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner? If "Yes," please explain. |
| 9- | <input type="checkbox"/> | <input type="checkbox"/> | 5 years | Been confined to a hospital, clinic, sanitarium or other medical facility? If "Yes," please explain. |
| 10- | <input type="checkbox"/> | <input type="checkbox"/> | 10 years | Been denied life, disability, medical or dental coverage? If "Yes," please explain. |
| 11- | <input type="checkbox"/> | <input type="checkbox"/> | 10 years | Been denied group coverage? If "Yes," please explain. |

Please give complete dates and details for all medical impairments checked using the space provided in section **G**.

- | | Yes | No | |
|-----|--------------------------|--------------------------|---|
| 12- | <input type="checkbox"/> | <input type="checkbox"/> | Within the past 10 years, has there been any disease/impairment of or treatment for any individual for any of the following? If "Yes," check the appropriate box(es) below and explain: |
| | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/AIDS Related complex |
| | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| | <input type="checkbox"/> | <input type="checkbox"/> | Back/Spine/Neck |
| | <input type="checkbox"/> | <input type="checkbox"/> | Blood pressure |
| | <input type="checkbox"/> | <input type="checkbox"/> | Blood Vessels |
| | <input type="checkbox"/> | <input type="checkbox"/> | Bones |
| | <input type="checkbox"/> | <input type="checkbox"/> | Brain |
| | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| | <input type="checkbox"/> | <input type="checkbox"/> | Carpal Tunnel Syndrome |
| | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| | <input type="checkbox"/> | <input type="checkbox"/> | Ears |
| | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| | <input type="checkbox"/> | <input type="checkbox"/> | Eyes |
| | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal Disorder |
| | <input type="checkbox"/> | <input type="checkbox"/> | Heart |
| | <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| | <input type="checkbox"/> | <input type="checkbox"/> | Immune Systems Disorder |
| | <input type="checkbox"/> | <input type="checkbox"/> | Intestines |
| | <input type="checkbox"/> | <input type="checkbox"/> | Kidney/Bladder |
| | <input type="checkbox"/> | <input type="checkbox"/> | Liver |
| | <input type="checkbox"/> | <input type="checkbox"/> | Lungs |
| | <input type="checkbox"/> | <input type="checkbox"/> | Mental/Nervous Disorder |
| | <input type="checkbox"/> | <input type="checkbox"/> | Nervous System |
| | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| | <input type="checkbox"/> | <input type="checkbox"/> | Reproductive System Disorder |
| | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| | <input type="checkbox"/> | <input type="checkbox"/> | Skin |
| | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| | <input type="checkbox"/> | <input type="checkbox"/> | Substance Abuse |
| | <input type="checkbox"/> | <input type="checkbox"/> | Surgical Operation |
| | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid |
| | <input type="checkbox"/> | <input type="checkbox"/> | Tumor Growth |
| | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer |

F. HEALTH RELATED INFORMATION (continued)

Dental Questions. Not required for CARE & SELECT options. Must be completed when ELITE option is chosen. Please provide details about all dental questions answered as **Yes** in section **G**.

13- Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any fillings needed? If "Yes," how many? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any teeth need extraction?
<input type="checkbox"/>	<input type="checkbox"/>	Any crowns needed?	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal disease needing treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Any denture/bridgework needed?	<input type="checkbox"/>	<input type="checkbox"/>	Any orthodontic treatment needed?
<input type="checkbox"/>	<input type="checkbox"/>	Missing teeth needing replacement?	<input type="checkbox"/>	<input type="checkbox"/>	Any surgery needed?
<input type="checkbox"/>	<input type="checkbox"/>	Periapical disease (i.e., root canal) needing treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Other <input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	Have all individual(s) had a dental exam within the last 12 months? If "No," give details.			
<input type="checkbox"/>	<input type="checkbox"/>	Does any individual(s) have a known physical impairment(s) or ill health not mentioned above? If "Yes," give complete dates and details.			

G. ADDITIONAL INFORMATION

Please use this section to provide additional information for questions answered in section F. Please provide all details including names, dates and details of the diagnosis and treatment. Please specify what individuals each situation applies to.

Check here if you are providing additional information on a separate attachment.

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I will inform WEA, Ltd. of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for coverage and I acknowledged that I have been given the option to print via PDF a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable, I understand that conditions which are disclosed on this form may be subject to all conditions of my plan including any pre-existing condition limitations, employee actively at work and dependent health conditions requirements. I also acknowledge that I am applying for this insurance for my assignment and/or residency outside the United States. My electronic signature indicates that I have reviewed all information and statement on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medial Information Bureau: You are authorized to provide WEA, Ltd. and AAUG Insurance Company, and their representatives, information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed. I agree that a photographic copy of this authorization is as valid as the original.

Applicant or Authorized Person's Electronic Signature	<input type="text"/>	Date Signed (MM/DD/YY)	<input type="text"/>
Spouse's or Authorized Person's Electronic Signature (must sign when spouse coverage is requested)	<input type="text"/>	Date Signed (MM/DD/YY)	<input type="text"/>

WEA, LTD. USE ONLY

Administrator Signature	<input type="text"/>	Date Processed (MM/DD/YY)	<input type="text"/>
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H. PREMIUM PAYMENT OPTIONS

A check payable to **WEA** for the first month's premium or a credit card authorization must be included with this application. We cannot process any applications without the deposit premium. We will not cash any checks or process any credit cards until after the policy has been approved.

CALCULATE YOUR PREMIUM (Enter the annual premium for each applicant. Two dependents under the age of 10 are FREE of charge when both parents apply for coverage):

Policy Holder	\$	<input type="text"/>
Spouse	\$	<input type="text"/>
1st Dependand Child	\$	<input type="text"/>
2nd Dependand Child	\$	<input type="text"/>
3rd Dependand Child	\$	<input type="text"/>
4th Dependand Child	\$	<input type="text"/>

C: Optional Term Life & AD&D

<input type="checkbox"/>	\$10,000	(\$40 annual)
<input type="checkbox"/>	\$25,000	(\$100 annual)
<input type="checkbox"/>	\$50,000	(\$200 annual)
<input type="checkbox"/>	\$75,000	(\$300 annual)
<input type="checkbox"/>	\$100,000	(\$400 annual)

A: Sub Total \$

D: Payment Factors:

<input type="checkbox"/>	Annual	(x 1)
<input type="checkbox"/>	Semi-Annual	(x .55)
<input type="checkbox"/>	Quarterly	(x .28)
<input type="checkbox"/>	Monthly	(x .10)

B: Optional Maternity Rider \$2,500 (Available on CARE and SELECT options only). ELITE option includes maternity benefits.

A	+	B	+	C	=	<input type="text"/>	X	D	=	\$ <input style="border: 2px solid red;" type="text"/>
		(if chosen)		(if chosen)						Total Premium Due

Credit Card Payments




Billing Address:

Name	<input type="text"/>		
Street	<input type="text"/>		
City	State	Zip	
Phone #	Phone #		
Fax	E-mail		

Overseas Communications:

Name	<input type="text"/>		
Street	<input type="text"/>		
City	Country	Zip	
Phone #	Phone #		
Fax	E-mail		

Credit Card Authorization:

<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Credit Card Number	<input type="text"/>				
Billing Address	<input type="text"/>				

Expiration Date (MM/DD/YY)	<input type="text"/>
Name as it appears on card	<input type="text"/>
Daytime Phone	<input type="text"/>

I authorize WEA, LLC. to debit my Visa/ MasterCard/ American Express account for the total amount due. If I have elected installments, I authorize WEA, Ltd. to debit my account for the proper installment amounts on the due dates of those installments. This authorization will remain in effect for up to 12 months or longer if the policy is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card Company.

Signature

I. PRODUCER INFORMATION (FOR OFFICE USE ONLY)

Producer Code	<input type="text"/>	Producer Name	<input type="text"/>
Company Name	<input type="text"/>	E-mail	<input type="text"/>
Signature	<input type="text"/>		

Address

