



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

Date

Primary Insured Social Security or ID

Requested date of change (must be first of a month unless adding new children)

A. CHANGE OF DEPENDENTS

Name	Relationship	Social Security #	Date of Birth	Date of Marriage Birth or Adoption ¹	Add	Remove
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Yes No

If you are adding a new child to your policy, was this child conceived using artificial insemination, surrogacy, or any other pregnancy assistance methods? If the answer is yes, this child is subject to full underwriting.

(1) Medical Underwriting and approval may be required to add dependents. If the dependent spouse is to remain in the United States, the higher U.S. rate will apply.

B. TERMINATE POLICY - EFFECTIVE DATE OF TERMINATION

C. CHANGE OF AVAILABLE BENEFITS: Change of available benefits: Please select the benefit that you wish to add or remove from coverage. Some changes in coverage will require new underwriting.

Add	Remove		Add	Remove		Face Amount
<input type="checkbox"/>	<input type="checkbox"/>	\$250 deductible	<input type="checkbox"/>	<input type="checkbox"/>	ELITE Option	<input type="checkbox"/> \$10,000
<input type="checkbox"/>	<input type="checkbox"/>	\$500 deductible	<input type="checkbox"/>	<input type="checkbox"/>	SELECT Option	<input type="checkbox"/> \$25,000
<input type="checkbox"/>	<input type="checkbox"/>	\$1,000 deductible	<input type="checkbox"/>	<input type="checkbox"/>	CARE Option	<input type="checkbox"/> \$50,000
<input type="checkbox"/>	<input type="checkbox"/>	\$2,500 deductible	<input type="checkbox"/>	<input type="checkbox"/>	Worldwide Coverage	<input type="checkbox"/> \$75,000
<input type="checkbox"/>	<input type="checkbox"/>	\$5,000 deductible	<input type="checkbox"/>	<input type="checkbox"/>	Worldwide Coverage Excluding US	<input type="checkbox"/> \$100,000
			<input type="checkbox"/>	<input type="checkbox"/>	Maternity	

D: OTHER:

Signature

You may fax this signed form to (954) 241-2002 or mail to:
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1 (954) 889-2100 | E-mail: info@wwexpa.com

WE MUST RECEIVE A WRITTEN, SIGNED REQUEST IN ORDER TO IMPLEMENT THE ABOVE CHANGE

A. 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	Federal ID	Sex: M / F	Date of Birth	Height Ft. In.	Weight Lbs.	Full Time Student
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>
								<input type="checkbox"/>

B. 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 **C**.

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do all dependent children live in your household? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do all dependent children depend on you solely for support? |
| <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 **C**.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is any individual pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there any inpatient or out patient medical or dental procedures (including diagnostic testing) recommended or contemplated? |
| <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. |
| <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> |
| <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. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5 years | Been confined to a hospital, clinic, sanitarium or other medical facility? If "Yes," please explain. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10 years | Been denied life, disability, medical or dental coverage? If "Yes," please explain. |
| <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 **C**.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <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 |

Dental Questions. Please give complete dates and details about all dental questions answered as **Yes** in section **C**.

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| 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? |

Continue on the next page →

