

Executive Health Options Application and Rates

Review your answers to each question on this Application for accuracy. Unanswered questions or incomplete information will delay processing. Be sure to answer all questions accurately and honestly. Any errors may cause the insurance to be voided. Your application becomes a permanent part of your contract.

Signatures: All Applications must be signed and dated in Part 6 by the applicant and spouse and /or adult children, if they are applying:

The **signature date** determines the active period for this application. The **effective date** (see Part 1) can be no more than 30 days after the signature date. *(This means that, under most circumstances, your application will expire 30 days after the signature date.)*

Part 1 If you are a US citizen, or a dual US/Canadian citizen or if you are currently in the US, you must provide your anticipated date of departure from the US and your anticipated length of residence outside the US.

Parts 2 and 3: Full details, including treatment dates, name, address and telephone number of attending physician, diagnosis, prognosis and present course of treatment (including medications) must be provided in **Part 3** for all **YES answers in Part 2**. (If you need to enter a lot of detail, consider providing separate sheets for Parts 2 and 3 for each family member.)

All applicants must answer “Yes” or “No” to the **Family History question** in Part 3. If your answer is “Yes,” fill in the details in the blanks provided.

If you answered YES to question **2** (tobacco use) or **5** (alcoholic beverages more than 14 drinks a week), fill in the blanks in Part 3.

Part 5: Annual premiums may be paid by cheque, money order or credit card authorization. *We will not accept cheques or money orders for monthly, quarterly or semi-annual payment modes.* These payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your premium.

Do you go to Florida? Do you live in Florida? All applicants must answer the question in Part 5. The response to these questions helps us to determine whether payment of Surplus Lines taxes fees is necessary. The response will not impact the amount of your payment.

Note — for applicants with existing health conditions or possible lifestyle risks:

If your application is accepted it is likely that the contract will include a Rider limiting coverage of your preexisting condition for a stated period of time or an increase in premium. Prior to issuance of the contract you will be asked to sign and return the Rider(s) acknowledging your acceptance of the limitation(s).

You will never be charged above the standard rate without your written acceptance and signed authorization.

To expedite approval, first fax or e-mail the completed application to CAPCO Health Group, **then mail it**. You will be informed within 5 business days whether the application is accepted or if any additional information is required to continue evaluation of your application.

Part 1 Failure to provide complete information will delay processing.

Coverage Area	Deductibles	Dental Rider	Term Life	Sports Rider
Worldwide, including US/Canada	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Requested Effective Date (must be within 30 days of signature)		Premium (from Part 5): \$		
Policy Language	"I hereby request that the policy be drafted and provided to me in the English language." «Je demand que la police soit rédigée elle me soit fournie en langue anglaise.»			

Note: Include only the family members applying for coverage. Attach additional sheets if necessary. Please print your name as you would like it to appear on your identification card.

Name (first name, middle initial, last name)		Date of Birth (mm/dd/yy)	Height	Weight	Citizenship
1. Applicant:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
2. Spouse:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
3. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
4. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
5. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			

Addresses must include: Street address, city, province, postal code, and country

Resident Address Outside of the United States (required if US citizen)	Mail Forwarding Address for Written Correspondence (if different from Resident Address)

Your Occupation:	Employer Name:
Date Hired:	Prior Employer (if within 2 years):

Home Telephone Number:	Work Telephone Number:
Fax Number:	E-mail Address:

If you or any family member are a US citizen or if you are currently in the US, the following information is required:	
Date of Departure from US:	Length of Residence outside of US:

Part 2

Please answer all questions for all members of the family included in this Application. Provide details of each "Yes" answer in Part 3.	Yes	No
1. Have you ever had an application for health or life insurance voided, declined, cancelled, rescinded or modified (including medical exclusion riders)?		
2. In the last 24 months, have you used tobacco in any form? If yes, please specify type and frequency in Part 3.		
3. In the last 12 months, have you experienced a weight change of 15 pounds or more?		
4. In the last 5 years, have you had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any alcohol or drug related arrest?		
5. In the last 5 years, have you consumed alcoholic beverages in excess of 14 drinks per week? If yes, please specify type and how much per week in Part 3.		
6. Are you pregnant or do you have an adoption pending?		
7. Do you (not including dependant children) read, write, speak and understand English? If no, what is your primary language?		
8. In the last 12 months, have you taken medication or received medical advice or treatment of any kind?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease or disorder of:	Yes	No
9. Gallbladder, pancreas, or liver?		
10. Skin?		
11. Joints or spine?		
12. Kidney?		
13. Eyes, ears, or nose?		
14. Mouth, throat, or jaw?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of:	Yes	No
15. High blood pressure?		
16. Chest pain?		
17. Headaches?		
18. Paralysis?		
19. Arthritis?		
20. Convulsions or epilepsy?		
21. Elevated cholesterol?		
22. Sexually transmitted disease?		
23. Cancer?		
24. Diabetes or sugar in the blood or urine?		
25. Stroke?		
26. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?		
27. Tumour, cyst, polyp, lump or growth of any kind?		
In the last 10 years, have you:	Yes	No
28. Had a complicated pregnancy or delivery?		
29. Tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional or received medical advice or treatment for a mental health condition?		
In the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease, disorder, or abnormality of the:	Yes	No
32. Heart or circulatory system?		
33. Nervous system?		
34. Digestive system?		
35. Muscular or skeletal system?		
36. Respiratory system?		
37. Male or female reproductive system?		
38. Urinary system?		
39. Thyroid, breast, or other glands?		
40. In the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse or abnormal test results?		

Part 3

For any question answered "Yes" in Part 2, please state the name of the family member and corresponding question number from Part 2. Provide complete details of medical condition including: treatment dates, name, address and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Attach additional sheets if necessary. Additional information may be requested.

#2 – Tobacco use (type and frequency of use)	#5 – Alcohol use (type and frequency of consumption)
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Individual's Name and Question Number from Part 2	Condition / Diagnosis	Dates of Treatment / Prognosis / Degree of Recovery	Type(s) of Treatment and Present Course of Treatment	Physician and / or Facility Name, Address and Phone Number

Family History – Must be completed for all Applicants

Do you have a family history (mother, father, brother, and/or sister) of diabetes, cancer, heart disease, stroke, high blood pressure, and/or high cholesterol? Yes No If Yes, please complete the following (attach additional sheets if necessary):

Applicant name	Relationship	Condition	Age at onset	Current age, if living	Age at death, if deceased

Part 4

For each family member applying for Term Life insurance, please complete the following (**Term Life is not available for those in the United States**):

For each family member applying for Term Life insurance, please complete the following (Term Life is not available for those in the United States):	Coverage Elected
Applicant: Beneficiary:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Spouse: Beneficiary:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Child: Beneficiary:	<input type="checkbox"/> Option 1

Provide full address for each Beneficiary listed above (attach additional sheets if necessary):

I understand Term Life and AD&D insurance will not become effective until the date of my departure from the US.
 _____ (Applicant initial here) _____ (Spouse initial here) _____ (Initial here for dependant children)

Part 5

PREMIUM CALCULATION

Applications without premium will not be processed. We will not accept checks or money orders for monthly, quarterly or semi-annual payment modes. For monthly, quarterly or semi-annual payment modes we will only accept a pre-authorized credit card. Checks, money orders or credit cards may be used for annual payment mode. Please make all checks and money orders payable to: HCC MEDICAL INSURANCE SERVICES (HCCMIS).

Use the rate tables found on page 7 to enter premium amounts for the Medical portion (column 1) and any options elected (columns 2 through 4) below. Add the amounts in columns 1 through 4 for each individual and note the totals in column 5.

	(1) Medical	(2) Optional Dental Rider	(3) Optional Term Life	(4) Optional Sports Rider	(5) TOTAL
Applicant:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Spouse:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
1 st Child:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2 nd Child:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3 rd Child:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Add all totals listed in column 5 and note the total here.					\$ _____ (Subtotal A)

Total First Payment Due

\$ _____ (Subtotal A)	X	_____	=	\$ _____
		*Modal Factor		
*Modal factors: <input type="checkbox"/> Annual 1.00 <input type="checkbox"/> Semi-annual .55 <input type="checkbox"/> Quarterly .28 <input type="checkbox"/> Monthly .20				
Optional express mailing fee: (\$20 in US, \$30 outside the US)				\$ _____
Total first payment due:				\$ _____

Remaining Payments (For semi-annual, quarterly, or monthly payment modes only)

\$ _____ (Subtotal A)	X	_____	=	\$ _____
		*Modal Factor		
*Modal factors: <input type="checkbox"/> Semi-annual .55 <input type="checkbox"/> Quarterly .28 <input type="checkbox"/> Monthly .10				
Premium due for each additional installment :				\$ _____

Monthly payments are available only if valid e-mail address is provided: _____
All correspondence regarding monthly payments will be made via e-mail to this address. For monthly payment mode, there will be 10 additional monthly payments after the initial payment. If you elect monthly payments, the 11 payments will be drawn during the first 11 months of coverage.

Florida Surplus Lines – All applicants: Please indicate whether either of the following statements applies to you.

I am a Florida Resident who will be living and working abroad during my Certificate Period. I may return home for short periods of time.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am a non-Florida resident who is coming to Florida for vacation or other non-work purposes.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part 6

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to Members by Lloyd's. I have personally completed this Application. I represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I understand HCC Medical Insurance Services relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I understand that any misrepresentation or omission contained herein will void my insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by HCC Medical Insurance Services. I understand that if this Application is not accepted, the sole obligation of HCC Medical Insurance Services is to return to me any premium I have paid. I understand that this insurance contains a Pre-existing Condition exclusion, a Pre-certification penalty, and other restrictions, exclusions and limitations. I understand that I may obtain a copy of the Master Policy upon request to HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand that the insurance agent/broker, if any, assisting me with this Application is a representative of the Applicant. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis or physical or mental condition of any family member listed on this Application to release said information to HCC Medical Insurance Services.

Signature of Applicant, Guardian, or Power of Attorney

Signature of Spouse

Date of Signature

Date of Signature

Method of Payment

Check or Money Order (annual payments only) American Express Discover MasterCard VISA

All payments must be made in US Dollars. If paying by credit card, I authorize HCC Medical Insurance Services to debit my VISA/MasterCard/American Express/Discover account for the total amount due. If I have selected monthly, quarterly, or semi-annual payment modes, I hereby request and authorize HCC Medical Insurance Services to debit my credit card account for the proper installment amounts on their respective due dates. This authorization will remain in effect for up to 12 months or longer if the Certificate 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.

* Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please mail your Check or Money Order along with this Application to: Bank of America Lockbox Services • c/o Lockbox # 15748 • 540 W. Madison, 4th floor • Chicago, IL 60661

Credit Card Number:

Expiration Date (mm/yy):

Name as it appears on card:

Billing Address:

Daytime Phone Number:

Signature:

Part 7

Producer Number:

Producer Name:

Company Name:

Street Address:

City: _____

State:

Postal Code:

Country:

Telephone:

Fax:

E-mail Address:

Signature:

THIS MEDICAL AND DENTAL INSURANCE IS UNDERWRITTEN BY SYNDICATE 4141 AT LLOYD'S, LONDON. THIS LIFE INSURANCE IS UNDERWRITTEN BY SYNDICATE 308, ALSO AT LLOYD'S. THE INSURANCE IS AVAILABLE TO MEMBERS OF THE ATLAS/INTERNATIONAL CITIZEN GROUP INSURANCE TRUST, HAMILTON, BERMUDA. LLOYD'S IS AN APPROVED, NON-ADMITTED INSURER IN ALL STATES OF THE UNITED STATES, EXCEPT KENTUCKY AND ILLINOIS WHERE THEY ARE ADMITTED. CLAIMS UNDER THIS INSURANCE MAY NOT BE MADE AGAINST ANY STATE GUARANTY FUND.

Executive Health Options Rate Table

Worldwide Medical Coverage Including the US and Canada

New Business Annual Rates for Standard Risk *

AGE	\$250 Deductible		\$500 Deductible		\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
14 days to 9 ^{1,2}	846	846	669	669	505	505	419	419	323	323
10 to 18 ²	1,184	1,184	952	952	735	735	639	639	518	518
19-24	1,169	1,539	942	1,371	732	1,026	646	909	530	734
25-29	1,209	1,799	989	1,592	766	1,143	674	1,005	554	875
30-34	1,336	2,014	1,099	1,769	855	1,315	758	1,163	620	981
35-39	1,451	2,232	1,208	1,900	934	1,460	828	1,281	676	1,094
40-44	1,872	2,445	1,549	2,047	1,201	1,588	1,066	1,411	869	1,121
45-49	2,106	2,543	1,881	2,150	1,458	1,672	1,293	1,479	1,055	1,142
50-54	3,780	4,078	3,644	3,930	3,375	3,638	2,860	3,074	2,293	2,448
55-59	5,056	4,975	4,902	4,810	4,574	4,480	3,945	3,842	3,229	3,115
60-64	6,227	5,724	6,046	5,552	5,676	5,202	4,971	4,527	4,144	3,739
65-69	14,397	12,555	13,872	12,030	12,826	10,978	9,973	8,299	8,651	7,304
70	16,976	14,677	16,443	14,162	15,381	13,099	12,128	9,845	10,520	8,510
71	17,771	15,379	17,240	14,851	16,178	13,787	12,773	10,381	11,080	8,973
72	18,451	15,963	17,926	15,437	16,875	14,386	13,328	10,842	11,562	9,370
73	19,152	16,550	18,632	16,030	17,589	14,990	13,904	11,301	12,061	9,768
74	20,085	17,342	19,563	16,822	18,522	15,781	14,645	11,901	12,704	10,288

¹ First 2 children age 14 days to 9 years are free only when both parents are insured under the Plan.

² Dependant Child rate is only available when parent (guardian) is insured under the Plan. Dependant children alone pay the age 19 to 24 male rate.

OPTIONAL BENEFITS

Optional Sports Rider	\$250.00
Optional Dental	\$492.00 ^o
^o except US citizens	\$348.00

NOTE: This document is provided for your reference only.
See the Certificate of Insurance for precise wording.

This plan is underwritten by Lloyd's, London, Syndicate 4141.
Lloyd's is licensed to do business in all Provinces of Canada.
The Plan Administrator is HCC Medical Insurance Services, a
Lloyd's Coverholder, located at
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204, USA



Optional Term Life and AD&D Insurance

AGE	OPTION 1	OPTION 2
19-29	\$130	\$ 230
30-39	\$210	\$ 370
40-44	\$310	\$ 545
45-49	\$450	\$ 790
50-54	\$570	\$1000
55-59	\$770	\$1350
60-64	\$585	\$1025
65-69	\$315	Not available
Dependant Child	\$ 85	Not available

* All rates and benefits are in U.S. dollars
Underwriters may assess additional fees after evaluating height/weight ratio.
Exclusionary Riders may be assigned for Pre-existing Conditions.

Rates are effective May 1, 2011
Rates include Surplus Lines taxes and fees when applicable