APPLICATION FORM

Best Doctors®

BEST DOCTORS INSURANCE LIMITED

Important: Please make sure all the information required on this health insurance application has been provided. Best Doctors Insurance Limited reserves the right to contact the applicant if a question has not been answered in detail or if additional information is needed. Any incomplete applications will be returned to the applicant for more information, delaying the processing of your application.

- ☐ **New application**
- ☐ Change my current plan/deductible
- ☐ Add spouse/partner/dependents
- ☐ Reinstatement

APPLICANT INFORMATION

LAST NAME(S)

FIRST NAME(S)

STREET ADDRESS

CITY

COUNTRY

EMAIL ADDRESS

TELEPHONE (OFFICE OR MOBILE NUMBER)

FAX

DATE OF BIRTH (M/D/Y)

HEIGHT ☐ M ☐ FT

WEIGHT ☐ KG ☐ LB

OCCUPATION

GENDER

- ☐ Male
- ☐ Female

STATUS

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced

Continued over

⁝⁝⁝ SELECT PLAN

- ☐ Premier Plus
- ☐ Global Care+
- ☐ Ultimate Care
- ☐ Advanced Care
- ☐ Corporate Choice
- ☐ Other _____

SELECT DEDUCTIBLE

- ☐ I
- ☐ II
- ☐ III
- ☐ IV
- ☐ V
- ☐ VI

ADDITIONAL COVER (RIDER)

- ☐ Maternity Complications
- ☐ Organ Transplant
- ☐ Critical Select
- ☐ Other _____

⁝⁝⁝ DEPENDENT'S INFORMATION

1. FIRST AND LAST NAME(S) _____ GENDER ☐M ☐F

RELATION TO APPLICANT _____ DATE OF BIRTH (M/D/Y) _____ HEIGHT ☐M ☐FT _____ WEIGHT ☐KG ☐LB _____ PREMIUM (USD)

2. FIRST AND LAST NAME(S) _____ GENDER ☐M ☐F

RELATION TO APPLICANT _____ DATE OF BIRTH (M/D/Y) _____ HEIGHT ☐M ☐FT _____ WEIGHT ☐KG ☐LB _____ PREMIUM (USD)

3. FIRST AND LAST NAME(S) _____ GENDER ☐M ☐F

RELATION TO APPLICANT _____ DATE OF BIRTH (M/D/Y) _____ HEIGHT ☐M ☐FT _____ WEIGHT ☐KG ☐LB _____ PREMIUM (USD)

4. FIRST AND LAST NAME(S) _____ GENDER ☐M ☐F

RELATION TO APPLICANT _____ DATE OF BIRTH (M/D/Y) _____ HEIGHT ☐M ☐FT _____ WEIGHT ☐KG ☐LB _____ PREMIUM (USD)

5. FIRST AND LAST NAME(S) _____ GENDER ☐M ☐F

RELATION TO APPLICANT _____ DATE OF BIRTH (M/D/Y) _____ HEIGHT ☐M ☐FT _____ WEIGHT ☐KG ☐LB _____ PREMIUM (USD)

_____ APPLICANT (SELF) PREMIUM (USD)

_____ RIDER (USD)

75 ANNUAL ADMINISTRATION FEE (USD)

_____ **TOTAL (USD)**

⁝⁝⁝ INFORMATION REGARDING ANY OTHER MEDICAL COVERAGE

☐Y ☐N Indicate if you or any of your dependents have any other type of international health insurance. **If YES,** please attach a copy of the plan's certificate of coverage and last payment receipt.

☐Y ☐N Do you intend to continue being insured with the other company?

☐Y ☐N Have you ever had an application for health insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? **If YES,** please enclose complete information.

☐Y ☐N Have you ever been insured by Best Doctors Insurance Limited or any one of its affiliates?

If YES, indicate date (M/D/Y) _____

If this is a change of plan/deductible, please indicate previous policy number _____

⁝⁝ MEDICAL QUESTIONNAIRE ANSWER [Y] **YES** OR [N] **NO** TO ALL QUESTIONS BELOW

SECTION A: To the best of your knowledge, have any of the persons listed on this application had any of the following conditions during the last ten (10) years?

[Y] [N] a) Cancer, malignant tumors or benign tumors. **If YES,** indicate type _____

[Y] [N] b) Kidney stones, kidney or bladder problems, urinary frequency or burning

[Y] [N] c) Goiter, thyroid problems or diabetes

[Y] [N] d) Epilepsy, paralysis, mental or nervous diseases, alcoholism, migraines

[Y] [N] e) Drug addiction for which the individual has been treated or hospitalized

[Y] [N] f) Gall bladder problems, hernia, stomach or intestinal problems, ulcers, hemorrhoids, liver problems

[Y] [N] g) Cataracts or other eye problems, ear problems

[Y] [N] h) Tuberculosis, pulmonary diseases, asthma or bronchitis, sinusitis, chronic cough and throat problems

[Y] [N] i) Arthritis, rheumatism, joint deformation due to arthritis, spine problems, gout

[Y] [N] j) Heart disease, blood pressure problems, anemia, rheumatic fever, bleeding/clotting disorders of the blood, hemophilia, phlebitis, thrombosis, chest pain, angina, aneurysm

[Y] [N] k) Female: Menstrual alterations or menstrual hemorrhage, disorders of the reproductive organ, sexually transmitted diseases, breast disorders

[Y] [N] l) Female: Presently pregnant. **If YES,** indicate date of delivery (M/D/Y) _____

[Y] [N] m) Female: Indicate number of: Pregnancies _____ Childbirths (normal or c-section?) _____ Abortions _____

[Y] [N] n) Female: Complications of pregnancy or childbirth, twin pregnancy or a child with any birth defect, congenital disease or hereditary condition

[Y] [N] o) Male: Prostate problems, sexually transmitted diseases

[Y] [N] p) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)

[Y] [N] q) Dermatitis or skin diseases, skin cancer, or any other skin problem

[Y] [N] r) Deviated septum, sinusitis, polyps, or other disorders of the noses

[Y] [N] s) Birth defects and congenital abnormalities, developmental delay, Down syndrome, heart/lung/kidney malformation

[Y] [N] t) Is any applicant a candidate for or recipient of, an organ, bone marrow or stem cell transplant?

SECTION B: Besides the health problems mentioned in Section A, to the best of your knowledge and understanding is there any person listed on this application who during the last five (5) years:

[Y] [N] a) Has consulted a doctor or other provider for surgical or medical treatment or for advice regarding another illness not mentioned in Section A?

[Y] [N] b) Had any health problem or symptom not mentioned in Section A or on Question (a) of this section, for which he/she has or has not consulted doctors?

[Y] [N] c) Have taken or takes any kind of medicine on a regular basis? **If YES,** please state:

NAME OF PATIENT

DIAGNOSIS

TYPE OF MEDICINE AND DAILY DOSAGE | EXPENSE PER MONTH | LAST MEDICAL CHECK UP (M/D/Y)

NAME OF YOUR PRIMARY DOCTOR | TELEPHONE OF PRIMARY DOCTOR

ADDRESS OF PRIMARY DOCTOR

HAVE ANY OF THE PERSONS LISTED ON THIS APPLICATION LOST OR GAINED WEIGHT IN THE LAST 3 MONTHS? | HOW MUCH? KG/LB

WHAT CAUSED THE CHANGE IN WEIGHT?

SECTION C: If you have answered **YES** on any part of Sections A or B please provide complete information in this section and attach the medical report (you may use an additional page if you need more space).

1. NAME OF PATIENT | DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL | DATE (FROM/TO)

2. NAME OF PATIENT | DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL | DATE (FROM/TO)

3. NAME OF PATIENT | DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL | DATE (FROM/TO)

ACKNOWLEDGEMENT AND AUTHORIZATION

IT IS UNDERSTOOD AND AGREED THAT:

a) Best Doctors Insurance Limited (the Insurance Company) reserves the right to accept or reject your enrollment application. The coverage provided will not become effective until the Insurance Company has received premium payment, completed underwriting, approved the application, and issued the policy. The coverage will become effective on the first or fifteenth day of the month following the date on which the Insurance Company approves the application.

b) The statements and answers provided are complete, accurate, true, and not misleading according to my best knowledge and understanding (full information). If you have not provided full information on this Application, then the Insurance Company in its sole discretion, without an obligation of reasonableness, may terminate and/or annul the policy issued to you without prior notice.

c) In the event of a termination as set forth in (b) above, the Insurance Company shall have no obligations of any nature to pay or reimburse any claims originally submitted or due to be submitted pursuant to the policy, subject to a reimbursement by the Insurance Company of any remainder of the policy premium due as calculated pursuant to the early termination provisions of the policy less any amount of benefits paid under the policy prior to this termination for false.

d) You shall be obligated to refund to the Insurance Company any moneys you received from the Insurance Company for benefits if your policy is terminated or annulled due to failure to provide Full Information and your reimbursement as described in (c) above is not sufficient for the Insurance Company to collect the amounts due.

e) Upon presentation of a photocopy or original of this signed Application, I authorize any physician, professional, hospital, clinic, or other medical provider, government agency or other person or company to provide the Insurance Company information including copies of records concerning counsel, care or treatment provided to me and/or my dependent(s), without limitation to information concerning mental illness or use of drugs or alcohol.

f) You and your covered dependents specifically understand and agree that each has elected to allow the agent of record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates or subcontractors.

SIGNATURE OF APPLICANT | SIGNATURE OF AGENT

DATE (M/D/Y) | AGENT NAME | AGENT CODE

PAYMENT INFORMATION

PAYMENT MODE

- ☐ Annual
- ☐ Semi-Annual

PAYMENT METHOD

- ☐ **Credit card**
- ☐ **Cheque:** Make payable to Best Doctors Insurance Limited.
- ☐ **Wire transfer**

PAYMENT SUMMARY

PREMIUM (USD)

RIDER (USD)

75
ANNUAL ADMINISTRATION FEE (USD)

TOTAL (USD)