



INDIVIDUAL/FAMILY APPLICATION FORM

INTERNATIONAL PRIVATE HEALTHCARE APPLICATION FORM FOR INDIVIDUALS AND FAMILIES

Directions For the Completing of The Application

1. Please print or type all information. Illegible information will delay underwriting and processing of your coverage.
2. Each Family member requesting coverage must be listed on the Application. All Questions on the Application apply to all applicants requesting coverage. Answer each and every question, as it pertains to each application listed on the Application. All members of a family must choose the same Deductible and the same level of cover.
3. Each Section of the application must be completed in full. Any question where a "Yes" was marked must be described in detail in Section 3. Information in Section 3 must include the applicant's name, physician's name, address and phone number, and address of treating facility, diagnosis, prognosis, and course of treatment. If necessary, use an additional sheet of paper to describe the condition(s) and attach it to the Application when submitted to JSL.

4. The Premiums listed are annual premiums and can be paid by cheque, bank transfer, VISA®, MasterCard®. Due to the inconsistent reliability of international mail, quarterly and semi-annual payments can be made by using a credit, debit card or bank transfer. Quarterly and semi-annual payment modes are only accepted with preauthorisation to debit your credit or debit card on the due date of your premium instalments.

5. Once the Coverholder underwrites your application and determines that coverage should be issued, we will send you an ID card and a Certificate of Coverage by mail. The Certificate of Coverage contains the full program wording and definitions. This package will also include details on how to submit a claim as well as information regarding the Coverholder's Pre-Notification Program.

SECTION 1

Insured Name/Details						
Surname:			Forename:		Initial:	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>			Social Security Number:			
Coverage Requested: Employee/Primary Member, Plus Dependents			Date of Birth (mm/dd/yyyy) / /			
Personal Mailing Address:						
City/Province/ and Country:			Postal/Zip Code:			
Email Address:			Country of Foreign Assignment:			
Home Country:			Date of Foreign Assignment: / /			
Resident Phone Number:				Fax Number:		
Occupation:						
Daily Duties:				Business Phone Number		
Effective Date of Coverage (mm/dd/yy): / /			Nationalities of Insured			
Dependent Information (if applicable)						
Surname	Forename	DOB mm/dd/yyyy	Gender	Relationship to Insured	Provincial Gov't Health Care # (if applicable)	Country of Residence (if applicable)
		/ /	Select			
		/ /	Select			
		/ /	Select			
		/ /	Select			
		/ /	Select			

Coverage – Benefit Summary Location of Foreign AssignmentZone 1 Worldwide Including North America and Canada Zone 2 Worldwide Excluding North America and Canada **Medical Insurance**

Silver Plan	<input type="checkbox"/>	Annual Excess/Deductable		
		US\$50	<input type="checkbox"/> +5%	US\$500 <input type="checkbox"/> -11%
Gold Plan	<input type="checkbox"/>	US\$100	<input type="checkbox"/> Standard	US\$2,000 <input type="checkbox"/> -17%
		US\$250	<input type="checkbox"/> -3%	
Platinum Plan	<input type="checkbox"/>	Discounts available for higher Deductibles on request		

OPTIONAL SECTION FOR ADDITIONAL BENEFITS**Dental Insurance** Option 1 US\$ 370 Option 2 US\$ 730Accidental Death and Dismemberment

Available in units of US\$1,000 to a maximum of US\$200,000.

Amount Selected :

Occupation Annual Income & Currency

Beneficiary Designation for AD&D (if applicable)

Surname	Forename	DOB mm/dd/yyyy	Gender	Relationship to Insured	Country of Residence (If applicable)
		/ /			
		/ /			
		/ /			

Life and Disability Insurance

<input type="checkbox"/> Life Insurance	Available in units of \$10,000 to a maximum of US\$200,000 *Hauteville beneficiary form must be completed.	Amount Selected: \$
<input type="checkbox"/> Long Term Disability	60%, 66.7% or 70% of monthly earnings to a maximum of US\$7,500 per month	
Elimination Period <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 12 months	Percentage Selected: %	

Surname	Forename	DOB mm/dd/yyyy	Gender	Relationship to Insured	Country of Residence (If applicable)
		/ /			
		/ /			
		/ /			

SECTION 2

Payment Details 5% Surcharge on Semi and Quarterly payments		
Method of Payment		
<input type="checkbox"/> Cheque	<input type="checkbox"/> Money Order	<input type="checkbox"/> Visa
<input type="checkbox"/> Bank Transfer	<input type="checkbox"/> Debit Card	<input type="checkbox"/> Mastercard
Currency:		
<input type="checkbox"/> USD	<input type="checkbox"/> GBP	<input type="checkbox"/> Euro
Card Number:		
Expiration Date: / /	Debit card Issue No:	
Valid from Date: / /	Security Code:	
<i>Payments made by Credit Card will incur a 3% transaction fee. No Charge will be made for a UK debit Card Payment for Sterling applications</i>		
Name as it appears on Card:		
Daytime Telephone Number:		
Signature (Required):		
Banking Address:		

All premium payments must be made in Euros, U.S. Dollar or Sterling, cheques can be issued from a U.S or U.K bank and made payable to 'Journeyman Services Ltd'. If paying by credit or debit card, I authorise JSL to debit my credit card account for the total amount due. In the event that I have elected to *Pre-Authorise credit card payment instalments, I hereby request and authorise JSL to debit my credit card periodically as payment instalments become due. This authorisation will remain in effect until revoked by me in writing, and until JSL actually receives notice. Coverage purchased by credit or debit card is subject to validation and acceptance by the Credit Card Company. *For any instalment payment other than annual, I pre-authorise JSL to debit my credit card for the proper instalment account on the due date of the instalment.

*Sign here for Pre-Authorisation of Instalment Premiums

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Agent Information

Agents Name APRIL Medibroker
Address Unit 4, Rake House Farm, Rake Lane
City/State/Zip North Shields, Tyne & Wear, NE29 8EQ
Telephone Number (Incl Area Code)+44(0)191 296 6140
Email clientservices@medibroker.com
Fax: +44 (0)191 2576272

Agent Certification

I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses on this application nor any supplement to the application. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Application to review the application and the answers recorded to confirm completeness and accuracy.

_____ / /

Security

Certain Underwrites at Lloyds, London; Rated A 'Excellent' by A.M.Best and A+ 'Strong' by Standards and Poors.

Please mail or fax to :-

Journeyman Services Ltd
The Laurels Business Park,
Parkend Walk,
Sling Gloucestershire
GL16 8JJ UK
Email: sales@jsl.uk.com
Fax UK: + 44 (0) 1594 839444
Tel UK: + 44 (0) 1594 839333

Important Information

It is important to note that Journeyman is a program for international citizens and Lloyd's is an international entity. Thus, Lloyd's operates as an unauthorised insurer in most U.S. states. Coverage and benefits are not regulated by any U.S. state insurance department.

The information concerning Journeyman is not intended to be an offer to sell Journeyman Products or a solicitation by Journeyman Services Ltd at Lloyd's London in any jurisdiction where such an action would be unlawful or in which JSL or Lloyd's London is not qualified to do so. Journeyman may not be available in all situations or jurisdictions. For U.S. citizens, Journeyman is intended for persons living or travelling outside the United States.

Protecting Your Personal Information

We recognize and respect your right to privacy. Therefore, when you apply for coverage, we establish a confidential file that is kept in our office. We limit access to information in your file to authorized persons who require the information to perform their duties, to persons to whom you have granted access, and to persons authorized by law. We use the information to determine your eligibility for coverage and to administer the group benefits plan.

Authorizations and Declarations

- I hereby apply for coverage under the group benefits plan.
- I authorize:
 - Any healthcare provide, my plan administrator, other insurance companies, or benefits providers working with this plan to exchange information, when necessary to determine my eligibility for coverage and to administer the group benefits plan.
- If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.
- I certify that the information given is true, correct and complete to the best of my knowledge.

Applicant's Signature: Date (mm/dd/yyyy):

_____ / /

I hereby certify that the information stated on this form is true and correct to the best of my knowledge. Unless otherwise stated, where two or more beneficiaries are named, the proceeds shall be paid in equal shares. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

International ID Theft and Money Laundering – Relevant to EU Countries and direct sales only

To comply with FSA regulations we require 2 items for proof of ID prior to inception of the policy and receipt of any monies.

This can be in a number of formats – either

- Passport
- International Driving Licence (photo ID)

And also –

- a recognised utility bill of their postal address O/S (matching the policy details).

These can be provided electronically or by fax.

Section 3

Health Questionnaire – Primary Insured

Name of Employee Surname First Name Middle Initial			Telephone	Occupation –	Annual Salary
Address of Employee (number, street Street Apt. City Province Postal Code					Date of Birth (dd./mm/yy) / /

INCOMPLETE FORMS WILL BE RETURNED

To be completed by the Employee – Statement of Health – Answer Every Question – Give Details

1 Height m b) Weight kg lbs.

Have you ever received any treatment (including taking pills, injections or other medication) for, consulted a physician for, or been diagnosed as having:

- | | | | |
|---|--|--------------------------|--------------------------|
| | | No | Yes |
| 2 | a) dizzy spells, epilepsy, neurological disorder, psychiatric or mental disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) asthma, chronic cough, shortness of breath, or convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) high blood pressure? If yes provide BP Readings for the past 12-months | <input type="checkbox"/> | <input type="checkbox"/> |
| | d) pain in chest, stroke, angina, heart disorder, chest pains or circulatory –problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| | e) ulcer, liver disorder, colitis, chronic diarrhoea, hepatitis or any digestive disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | f) arthritis, rheumatism, gout, neck or back problem, disc disease, joint or bone disorder, chronic fatigue syndrome or fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| | g) cancer, tumor, leukaemia, enlarged glands or lymph nodes? | <input type="checkbox"/> | <input type="checkbox"/> |
| | h) diabetes, sugar in urine or thyroid disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | i) urine, kidney or bladder disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | j) anemia, bleeding or blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | k) difficulty with eyes or ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| | l) acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) | <input type="checkbox"/> | <input type="checkbox"/> |
| | m) a positive HIV (Human Immune Deficiency Syndrome) test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | a) Indicate your average weekly consumption of alcohol
Beer oz. Wine oz. Liquor oz. | | |
| | b) Have you ever been advised to stop drinking alcohol or to drink less? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | a) Have you ever been refused life or health insurance or been offered it on special terms? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) If you have recently applied for another insurance Policy, please provide:
Date: / / Policy No.
Name of Insurance Company: | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | |
|---|---|--------------------------|--------------------------|
| 5 | Do you have an annual check up
If “Yes” provide results: | No | Yes |
| | | <input type="checkbox"/> | <input type="checkbox"/> |
| | If “No” provide date and results of last check up. | | |

Date: / / Results:

In the past 5 years have you:

- | | | | |
|---|--|--------------------------|--------------------------|
| 6 | a) except for an annual check up, consulted a Doctor or other health practitioner, submitted to an ECG, blood tests, X – rays or other tests, had surgery or been treated in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) received or applied for disability benefits for 3 months or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) had a urinary tract infection or any sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Within the past 12 months, have:

- | | | | |
|----|--|--------------------------|--------------------------|
| 7 | a) your duties been modified due to health reasons? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) you been off work for more than 5 consecutive days due to illness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c) you used tobacco products?
If “Yes”, indicate the number per day | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | Within the past 10 years have you used cocaine, heroin, or other narcotics, marijuana, LSD or amphetamines, Except as prescribed by a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | Are you presently under medical treatment by diet, Medicine, or other means? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Do you engage in any of the following activities:
Skydiving, scuba diving, vehicle or boat racing, or aviation except as a passenger? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | a) For women: are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b) Have you ever had any complications of pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | In the past 12-months have you experienced any symptoms that you have not yet sought medical attention for ? | <input type="checkbox"/> | <input type="checkbox"/> |

Continued On Page Two

Name of Employee Surname First Name Middle Initial			Telephone	Occupation –	Annual Salary
Address of Employee (number, street Street Apt. City Province Postal Code					Date of Birth (dd./mm/yy) / /

For each “Yes” answer above, please give full details below. If you require more space, please attach a separate sheet of paper but remember to date, sign and staple it to this form.

Question #	Date(s)	Name and Address of Physician(s) & Hospital	Details

Authorization

I certify that the above statements and those on any attached sheet are true and complete. I authorize Norfolk Mobility Benefits Inc., and (a) any person or organization which has relevant personal information about me including other insurers, health professionals and institutions, and (b) persons who perform insurance functions or medical services for Norfolk Mobility Benefits Inc., to exchange such information as may be required for underwriting, administration and claim paying purposes. A photocopy of this authorization is as valid as the original.

_____ / /
Signature of Primary Insured

You should keep a copy of this Health Questionnaire for your records.