INDIVIDUAL HEALTH INSURANCE APPLICATION

The Insurer retains the right to contact the applicant if any question is not explained in detail or if additional information is required.

☐ New policy ☐ Additional dependents ☐ Change of product or plan

For company use
Policy number

1. PERSONAL INFORMATION

PLEASE PROVIDE COPY OF IDENTIFICATION DOCUMENT FOR EACH APPLICANT

Name of applicants (policyholder/dependents)	Relationship to policyholder	Marital status[1]	Date of birth	Sex	Weight	Height
First name M.I. / Last name	Self		Month/Day/Year	M ☐ F ☐	☐ lbs ☐ kg	☐ ft ☐ m

Citizenship	Country of birth	ID Type	Number

Name of applicants (policyholder/dependents)	Relationship to policyholder	Marital status[1]	Date of birth	Sex	Weight	Height
First name M.I. / Last name			Month/Day/Year	M ☐ F ☐	☐ lbs ☐ kg	☐ ft ☐ m
ID Type		Number				
First name M.I. / Last name			Month/Day/Year	M ☐ F ☐	☐ lbs ☐ kg	☐ ft ☐ m
ID Type		Number				
First name M.I. / Last name			Month/Day/Year	M ☐ F ☐	☐ lbs ☐ kg	☐ ft ☐ m
ID Type		Number				
First name M.I. / Last name			Month/Day/Year	M ☐ F ☐	☐ lbs ☐ kg	☐ ft ☐ m
ID Type		Number				

If this Application includes children between **19 and 24 years old**, are any of them a full-time student in a college or university? ☐ Yes ☐ No
If "Yes", please provide copy of a certificate or affidavit from the college or university as evidence of full-time student status.

If requesting coverage for a newborn baby, please answer the following question: ¿Was the baby born as a result of a fertility treatment, was adopted, o born from a surrogate mother? ☐ Yes ☐ No

If more space is required, please use an additional sheet, signed and dated. If additional sheet is used, please check here to confirm. ☐

[1] **S** – single **M** – married **DP** – domestic partner **D** – divorced **W** – widow/widower Note: A Treating Physician Statement is required for any person **age 65 or older**..

2. PRODUCT, PLAN, AND ADDITIONAL COVERAGE REQUESTED

Product:		Requested effective date of coverage:	Month/Day/Year
Deductible:		**Additional coverage:** If no additional coverage is selected, none will be granted.	
Requested effective date of coverage:		☐ Complications of maternity[2]	☐ Transplant procedures[3]

[2] Please fill out a Maternity Questionnaire [3] Please fill out an Application for Transplant Procedures Rider

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3. OTHER INSURANCE INFORMATION

(3.1) Do you have health insurance coverage with another company? ☐ Yes ☐ No

Company name				Telephone	
Product name		Deductible value		Policy number	

(3.2) Do you intend to keep your insurance coverage with the other company? ☐ Yes ☐ No

(3.3) If the requested coverage is replacing an existing insurance, please attach a copy of the certificate of coverage and receipt of last payment.

(3.4) Has any previous application for health or life insurance been declined, accepted subject to restrictions, or at a premium higher than the standard rates of the insurer for any of the applicants? ☐ Yes ☐ No

If "Yes", please explain	

4. GENERAL INFORMATION

(4.1) Residential address

Home					
Zip code		City/State		Country	
Mailing (if different from above)					
Zip code		City/State		Country	

(4.2) Are all dependents living in the same address indicated above? ☐ Yes ☐ No If not, please indicate dependent name and address.

Name		Address	
Name		Address	

(4.3) Residence/citizenship status

Are you a U.S. citizen or permanent resident of the United States of America? ☐ Yes ☐ No

If "Yes", are you currently residing or have you legally resided in the United States of America for more than 6 months in any one year period? ☐ Yes ☐ No

(4.4) Telephone, fax and e-mail

Home		Work		Fax	
Email					

5. BENEFICIARY INFORMATION

Name	Last name	First name	M.I.	Relationship to policyholder	
Name	Last name	First name	M.I.	Relationship to policyholder	

6. MEDICAL INFORMATION

(6.1) Family doctor(s)

Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	
Applicant's name		Doctor's name	
Specialty		Telephone	

6. MEDICAL INFORMATION (continued)

(6.2) Medical check-ups

Has any applicant had any pediatric, gynecological, or routine examination in the past five years? ☐ Yes ☐ No If "yes", please explain below.

Name		Type of exam		Date	Month/Day/Year
Result ☐ Normal ☐ Abnormal	If abnormal, please describe.				
Name		Type of exam		Date	Month/Day/Year
Result ☐ Normal ☐ Abnormal	If abnormal, please describe.				
Name		Type of exam		Date	Month/Day/Year
Result ☐ Normal ☐ Abnormal	If abnormal, please describe.				

If more space is required, please use an additional sheet, signed and dated. If additional sheet is used, please check here to confirm. ☐

(6.3) Medical questionnaire

This section must be completed with the medical information of **all policy members**, considering all current and previous conditions. Please make sure you declare everything about any condition and symptoms, known or suspected, even if you haven't yet sought medical care. The medical conditions listed are just examples of illnesses or conditions grouped according to body system, but do not limit or exclude other related conditions. If you are a current Bupa policyholder and would like to change your plan, you must also include your health information. This information will be reviewed by our underwriting team, who will evaluate the terms of your plan.

1	Eye, ear, nose, and throat disorders or dental problems like cataracts, glaucoma, retinopathy, visual impairment, deafness, recurrent ear infections, tonsillitis, dental infections, cavities, wisdom teeth problems or gingivitis, among others.	☐ Yes ☐ No
	Applicant(s) name	
2	Cardiovascular or circulatory system disorders like hypertension, high cholesterol, angina pectoris, arrhythmia, aneurysms, varicose veins, or deep vein thrombosis, among others.	☐ Yes ☐ No
	Applicant(s) name	
3	Endocrine (glandular) or metabolic disorders like diabetes (Type 1 or Type 2), thyroid problems, obesity, or Cushing's syndrome, among others.	☐ Yes ☐ No
	Applicant(s) name	
4	Respiratory or pulmonary disorders like asthma, chronic obstructive pulmonary disease (COPD), pneumonia, bronchitis, tuberculosis, or allergies (including hay fever and anaphylaxis), among others.	☐ Yes ☐ No
	Applicant(s) name	
5	Disorders of the esophagus, stomach, intestines, liver, pancreas, spleen or gall bladder like reflux, gastritis, esophagitis, Barrett's esophagus, ulcers, irritable bowel syndrome, chronic ulcerative colitis, diverticulitis, hemorrhoids, pancreatitis, hepatitis, cirrhosis, gall stones, or hernias, among others.	☐ Yes ☐ No
	Applicant(s) name	
6	Kidney or urinary disorders like kidney stones, renal insufficiency, recurrent urinary tract infections (UTI), or incontinence, among others.	☐ Yes ☐ No
	Applicant(s) name	
7	Muscle or skeletal disorders like arthritis, lumbago, spinal column ailments, neck/shoulder ailments, fractures, sprains, osteoporosis, gout, knee ailments, or cartilage and ligament problems, among others.	☐ Yes ☐ No
	Applicant(s) name	
8	Blood, infectious, or immunodeficiency disorders like abnormal blood test results, anemia, hepatitis, HIV/AIDS, malaria, systemic lupus erythematosus, idiopathic thrombocytopenic purpura (ITP), thalassemia, or any autoimmune disorder, among others.	☐ Yes ☐ No
	Applicant(s) name	
9	Cancer, tumors of any type, or pre-cancerous conditions like polyps, benign growths, breast nodules, cysts, or lipomas, among others.	☐ Yes ☐ No
	Applicant(s) name	
10	Skin disorders like eczema, dermatitis, rashes, psoriasis, acne, cysts, moles, or allergic conditions, among others.	☐ Yes ☐ No
	Applicant(s) name	
11	Brain or nervous system disorders like dementia, migraine, frequent headaches, paralysis, multiple sclerosis, epilepsy/convulsive seizures, neuralgia (including sciatica herpes zoster or shingles) or meningitis, among others.	☐ Yes ☐ No
	Applicant(s) name	
12	Psychiatric or psychological disorders like schizophrenia, eating disorders, depression, attention deficit disorder (ADD), anxiety or drug/alcohol dependency, among others.	☐ Yes ☐ No
	Applicant(s) name	
13	Congenital or hereditary disorders of any type.	☐ Yes ☐ No
	Applicant(s) name	
14	Cosmetic surgery like breast augmentation or reduction or rhinoplasty, among others.	☐ Yes ☐ No
	Applicant(s) name	
15	Are you currently under medical treatment and/or rehabilitation?	☐ Yes ☐ No
	Applicant(s) name	

6. MEDICAL INFORMATION (continued)

16	Are you or any of the applicants taking any medication or have been prescribed any medication?	☐ Yes ☐ No
	Applicant(s) name	
17	Any other illness, disorder, injury, accident or pending surgery/hospitalization not previously mentioned above?	☐ Yes ☐ No
	Applicant(s) name	
18	QUESTIONS FOR FEMALE APPLICANTS ONLY	
a	Are you pregnant?	☐ Yes ☐ No
	Applicant(s) name	
b	Have you had any pregnancy complications? ☐ Preeclampsia ☐ Eclampsia	☐ Yes ☐ No
	Applicant(s) name	
c	Have you had an ectopic pregnancy? Date: Month/Day/Year	☐ Yes ☐ No
	Applicant(s) name	
d	Have you had a dilation and curettage (D&C)? Date: Month/Day/Year Type	☐ Yes ☐ No
	Applicant(s) name	
e	Have you had an abortion? Date: Month/Day/Year Cause	☐ Yes ☐ No
	Applicant(s) name	
f	Have you had a cesarean section? Date: Month/Day/Year Cause	☐ Yes ☐ No
	Applicant(s) name	
g	Have you had any fertility/ infertility treatment? Date: Month/Day/Year Cause	☐ Yes ☐ No
	Applicant(s) name	
h	Have you had any sexually transmitted diseases or disorders of the female reproductive system (ovaries, uterus or mammary glands) like the human papillomavirus (HPV) infection, pelvic inflammatory disease, heavy or irregular menstruation, fibroids, endometriosis, infertility, abnormal cytologies, polycystic ovaries, etc.?	☐ Yes ☐ No
	Applicant(s) name	
19	QUESTIONS FOR MALE APPLICANTS ONLY	
a	Have you had any sexually transmitted diseases or disorders of the male reproductive system like prostatitis, benign prostatic hyperplasia (enlarged prostate), infertility, testicular disorders, mammary glands, among others?	☐ Yes ☐ No
	Applicant(s) name	

(6.4) Medical conditions/explanations

Letter		Applicant		Condition	
From	Month/Day/Year	To	Month/Day/Year	Treatment and results	
Current state of health				Doctor's information	
Letter		Applicant		Condition	
From	Month/Day/Year	To	Month/Day/Year	Treatment and results	
Current state of health				Doctor's information	
Letter		Applicant		Condition	
From	Month/Day/Year	To	Month/Day/Year	Treatment and results	
Current state of health				Doctor's information	

If more space is required, please use an additional sheet, signed and dated. If additional sheet is used, please check here to confirm. ☐

6. MEDICAL INFORMATION (continued)

(6.5) Medications

Is any applicant currently taking medication, or been advised at any time to take any medication? ☐ Yes ☐ No If "yes", please explain below.

Applicant		Name of medication		Amount			
Reason		Frequency		From	Month/Day/Year	To	Month/Day/Year
Applicant		Name of medication		Amount			
Reason		Frequency		From	Month/Day/Year	To	Month/Day/Year
Applicant		Name of medication		Amount			
Reason		Frequency		From	Month/Day/Year	To	Month/Day/Year
Applicant		Name of medication		Amount			
Reason		Frequency		From	Month/Day/Year	To	Month/Day/Year

If more space is required, please use an additional sheet, signed and dated. If additional sheet is used, please check here to confirm. ☐

(6.6) Habits

Has any applicant ever smoked cigarettes, consumed nicotine products, alcohol, or illegal drugs? ☐ Yes ☐ No If "yes", please explain below.

Applicant		Type		How long?		Amount per day	
Applicant		Type		How long?		Amount per day	
Applicant		Type		How long?		Amount per day	

(6.7) Family history

Does any applicant have a family history of diabetes, hypertension, cancer, or a congenital or hereditary cardiovascular disorder? ☐ Yes ☐ No
If "yes", please explain below.

Applicant	Relative with the disorder (please check)				Disorder
	Father	Mother	Sibling	Child	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

7. PAPERLESS CUSTOMER SIGN UP

☐ I hereby sign up as a paperless customer with Bupa Insurance Company. As a paperless customer, I will receive all documents and correspondence from Bupa by logging into Online Services at www.bupasalud.com.

8. ACKNOWLEDGEMENT AND AUTHORIZATIONS

I certify that I have read and reviewed all the answers and statements declared in this application and that to the best of my ability, they are complete and truthful. I understand that any omissions, incorrect or incomplete statements could cause claims to be denied, and the policy to be modified, cancelled, or rescinded. If any person requires medical care or treatment after the application for insurance is signed, but before the effective date of this policy, I will then provide full details to Bupa for final approval before coverage is effective. I agree to accept the policy with the terms and conditions as issued. Otherwise, I will notify my disagreement to Bupa in writing, within the first ten (10) days of receipt of the insurance policy.

Authorization to collect health information

I hereby authorize Bupa Worldwide Corporation and affiliates (collectively "Bupa") to request my and/or my dependents' protected health information including, without limitation, my and/or my dependents' medical records, any prescription medication records/history, treatment records or plans, and any other medical or pharmaceutical information to be considered in the underwriting decision upon my and/or my dependents' application. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), and any other organization or person, including any member of my family having access to any medical records or knowledge of myself or my health, to disclose such information to Bupa, its Business Associates, or its designated agents (collectively, "Bupa Entities") and the insurer.

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa Entities and the insurer will rely on such information to 1) underwrite this application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 3) administer coverage, and 4) conduct other insurance operations according to applicable law.

I understand that the ability to underwrite the insurance is dependent upon the receipt of all necessary health information. As such, my refusal to provide authorization (marking "No" below) will result in the rejection of my application for enrollment.

☐ Yes ☐ No

Authorization to disclose health information

I hereby authorize Bupa Worldwide Corporation and affiliates (collectively "Bupa") and the insurer to use and disclose my policy conditions, certificate of coverage, and other insurance documents, payment information, claims filings, and medical records which may contain protected health information, to my insurance agent/agency and its affiliates and successors to enable them to respond to my inquiries and facilitate interactions regarding my insurance coverage, payments, and claims.

☐ Yes ☐ No

I understand that:

- Bupa and the insurer will use any information supplied in this application and received through this authorization prior to the effective date of coverage in considering my application.
- Bupa and the insurer will comply with the Health Insurance Portability and Accountability Act of 1996 as amended and supplemented and the regulations thereto (HIPAA) and that the use and disclosure of information will be done under the applicable HIPAA statute and rules.
- I am entitled to receive a copy of this authorization.
- A copy of this authorization shall be as valid as the original.
- The authorization shall be valid for the complete term of the coverage, including automatic renewal.
- This is a voluntary authorization, and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and no longer protected under HIPAA.
- I have the right to revoke this authorization by notifying Bupa in writing and subject to and in accordance with 45 C.F.R. §164.508. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:
  Bupa Privacy Office
  17901 Old Cutler Road, Suite 400
  Palmetto Bay, Florida 33157 USA
  Privacyoffice@bupalatinamerica.com

I have reviewed and understand the content and purpose of the acknowledgement and authorizations. By signing or replying affirmatively, I am confirming that the authorization decisions noted above accurately reflect my wishes. My signature below constitutes acceptance of all items listed above. This application is valid for 90 calendar days as of the date of signature.

9. SIGNATURES

Applicant	Name	Signature	Date
Policyholder			Month/Day/Year
Spouse			Month/Day/Year

As Producer, I accept full responsibility for the submission of this application, for sending all the collected premiums, and for the delivery of the policy when issued. **I do not know of any condition that has not been disclosed in this application which will affect the insurability of the proposed insured(s).**

Producer's printer name	Producer's signature (witness)	Producer's code

10. PAYMENT INFORMATION (payment must be submitted with the application)

Policyholder's name		Policy No.	

Policy type:				
☐ Annual	Premium:	US$		
☐ Semi-annual	Optional coverage:	US$		
☐ Quarterly	Annual administrative fee:	US$	75.00	
	Total amount:	US$		

PAYMENT INFORMATION (continued)

Payment Method Option 1

☐ Cashier's check ☐ Check ☐ Money order ☐ Traveler's check
DO NOT SEND CASH. Payment must be made to Bupa Worldwide Corporation.

Payment Method Option 2

☐ Wire transfer

Bank information:	Bupa Worldwide Premium Trust Wells Fargo Bank, Cuenta #2000037371881, ABA #121000248, SWIFT #WFBIUS6S, CHIPS #0407

Payment Method Option 3

☐ ACH

Bank information:	Bupa Worldwide Premium Trust Wells Fargo Bank, Account #2000037371881, ABA #067006432

Payment Method Option 4

☐ Credit card Please provide the following information:

I	

, authorize Bupa Worldwide Corporation to charge my credit card: ☐ MasterCard ☐ VISA ☐ AMERICAN EXPRESS ☐ Diners Club International

Credit card number		Expiration date	Month/Year
Amount to charge: US$			

Cardholder's billing address (where the credit card statement is received):

Cardholder's telephone number:		Cardholder's signature	

Automatic debit for future renewals: ☐ Yes ☐ No

With my signature below, I hereby authorize Bupa Worldwide Corporation to debit the credit card account directly, as indicated above, and pay the insurance premiums of my Bupa health insurance policy.
I understand that if there are any changes to my Bupa health insurance policy, the amount of the approved premium may also change. I further understand that a true and correct copy of this document will be forwarded to my credit card institution. By signing this document, I request and instruct such institution to allow Bupa Worldwide Corporation to directly debit my account and pay the health insurance premium, unless I instruct otherwise in writing.
In the event that a direct debit to pay my Bupa health insurance premium is, for any reason, rejected or declined, I acknowledge that it will be my personal responsibility to immediately pay the premium of my health insurance policy or my policy may lapse, be cancelled and/or terminated.
By signing, I authorize automatic deductions for future renewals.

Policyholder's signature	Cardholder's signature	Date
		Month/Day/Year