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

Bupa

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	

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	

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	

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	

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]
Renewals/additions: ☐ Worldwide ☐ Select ☐ Prestige ☐ Choice		Deductible :	

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

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

Without prejudice to the conditions applicable to the payment of claims contemplated in this policy, in my capacity as policyholder I designate as beneficiary/s the next person/s, who may receive the benefits or payment of claims provided for in this policy in case of my death.

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

(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 Global 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.

SECTION 1

An affirmative answer to any of the following must go to the next section.

1	Do you have or have you had an illness or accident in the last five years? Answer yes if you have an illness, even if you have not been hospitalised or admitted.	Yes ☐ No ☐
	Applicant(s) name	
2	Are you or have you been admitted to any hospital or undergone any surgery? Answer YES if you have been admitted or underwent surgery at any hospital or medical center for any reason	Yes ☐ No ☐
	Applicant(s) name	
3	Are you currently under medication prescribed by a doctor? Answer YES, if you take any medication prescribed by a doctor	Yes ☐ No ☐
	Applicant(s) name	
4	Do you currently persistently or repeatedly suffer any undiagnosed symptoms or pain? Answer YES if you have recently had any symptom or pain that has not been studied or diagnosed	Yes ☐ No ☐
	Applicant(s) name	
5	Are you pregnant or have you ever been pregnant? If you answered "Yes", do you have or have you had any complications related to your pregnancy(s) (ectopic abortions/pregnancies/eclampsia/preeclamsia)? If yes, please complete the additional information section.	Yes ☐ No ☐
	Applicant(s) name	

Habits: Does the applicant and/ or dependent(s) smoke cigarettes or consume products with nicotine, alcohol or illegal drugs?					Yes ☐ No ☐
Applicant(s) name		Type		Frequency	

SECTION 2

1	Heart or Circulatory system diseases (for example, hypertension angina/chest pain, heart attack, heart failure, irregular heart rate, aneurisms, varicose veins, among others)	Yes ☐ No ☐
	Applicant(s) name	
2	Endocrine System Disorders (for example, type 1 or type 2 diabetes or thyroid problems, among others)	Yes ☐ No ☐
	Applicant(s) name	
3	Respiratory System Disorders (for example, Asthma, COPD, respiratory infections, pneumonia or bronchitis, among others)	Yes ☐ No ☐
	Applicant(s) name	
4	Digestive Disorders - oesophagus, stomach, intestines, liver or gallbladder (for example, gastritis, gastric ulcer, haemorrhoids, pancreatitis, acute hepatitis, cirrhosis, gallstones, biliary colic or hernias, among others)	Yes ☐ No ☐
	Applicant(s) name	
5	Dermatology - skin and appendages (for example, eczema, dermatitis, psoriasis, acne, among others)	Yes ☐ No ☐
	Applicant(s) name	

6. MEDICAL INFORMATION (continued)

6	Neurological System - cerebral or nervous system (for example, multiple sclerosis, stroke, epilepsy, migraines, neuritis, hemi or parplegia, among others)	Yes ☐ No ☐
	Applicant(s) name	
7	Musculoskeletal system (for example, arthritis, back pain, spinal disorders, joint disorders, whether operated on or not, fractures, surgeries, among others)	Yes ☐ No ☐
	Applicant(s) name	
8	Men's urology (for example, bladder, prostateor kidney diseases, urinary tract infections, renal colic due to kidney stones, incontinence among others)	Yes ☐ No ☐
	Applicant(s) name	
9	Women's urology/gynecology- urinary tract or gynecological diseases (for example, urinary infections, renal colic due to kidney stones, incontinence, ovarian cysts, mioma, among others)	Yes ☐ No ☐
	Applicant(s) name	
10	Haematology or immunology- Blood or immunological diseases (for example, Lupus, Anemias, Autoimmune disorders, among others)	Yes ☐ No ☐
	Applicant(s) name	
11	Diseases of the eyes, nose, ears or throat (for example, cataract, glaucoma, keratitis, sinusitis, among others)	Yes ☐ No ☐
	Applicant(s) name	
12	Psychiatry and Psychology (for example: Schizophrenia, eating disorders, Bipolar Disorder, Autism, Attention Deficit Hyperactivity Disorder(ADHD), among others)	Yes ☐ No ☐
	Applicant(s) name	
13	Cancer and Lymphoproliferative disorders- Cancer of any location including Leukemia and Lymphomas, precancerous conditions (for example, cervical lesions, actinic keratosis, among others)	Yes ☐ No ☐
	Nombre de la(s) solicitante(s)	
14	Congenital diseases- congential or inherited disorders of any kind (for example, Down Syndrome, cardiovascular or neurological malformations, amonth others)	Yes ☐ No ☐
	Applicant(s) name	
15	Relevant infectious and/ or sexually transmitted diseases (for example, chronic hepatitis, tubercolosis, HIV/ AIDS, malaria, among others)	Yes ☐ No ☐
	Applicant(s) name	
16	Any other illnesses, disorders, injuries, accidents or pending surgery/hospitalization not mentioned above?	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 the insurer 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 the insurer in writing, within the first ten (10) days of receipt of the insurance policy.

Authorization to collect health information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries 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").

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa Entities 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 Bupa's 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 Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") 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 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 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
  18001 Old Cutler Road, Suite 500
  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$		

RESTRICTED-CONFIDENTIAL WHEN COMPLETED

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$		Identity card number (for Venezuela residents only)	

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

Bupa Insurance Company
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