



INDIVIDUAL HEALTH INSURANCE (PLEASE PRINT CLEARLY)



26000 Towne Centre Drive Suite 100, Foothill Ranch, CA 92610 USA fax: (949) 457-3116 phone: (949) 470-2100 e-mail: myhealth@tiecare.com

PRIMARY APPLICANT:

Last Name: First Name: Date of Birth:
Male Female Nationality: Citizenship*: Height(feet/inches): Weight(lbs):
Occupation: Residence:
Applicants address:
Phone Number: e-mail:
Employer Name:
Employer address:

SPOUSE:

Last Name: First Name: Date of Birth:
Male Female Nationality: Occupation: Height(feet/inches): Weight(lbs):
Country of Residence:

DEPENDENT(S):

Last Name: First Name: Date of Birth:
Male Female Nationality: Occupation: Height(feet/inches): Weight(lbs):
Country of Residence:

Last Name: First Name: Date of Birth:
Male Female Nationality: Occupation: Height(feet/inches): Weight(lbs):
Country of Residence:

POLICY SELECTION: Check one: Worldwide (No area Exclusions) International (No Coverage U.S or Canada) International Plus (Emergency Coverage in the Restricted Areas)

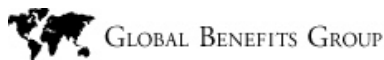
Requested Effective Date: Coverage Type: Single Married Single Parent Family Family
Annual Deductible: \$0 \$100 \$250 \$500 \$1,000 \$2,000 \$5,000
Per claim Deductible: \$10 \$25 \$50 \$75 \$100 \$125 \$150
Co-payment: 0% 10% 20% 30%

Preferred Method of Payment:

Under\$5,000. Premium Only Annually

Over\$5,000. Premium Only

Semi-Annual (add a 5% surcharge) Quarterly (add a 5% surcharge) Monthly (add a 5% surcharge)



Member Health Statement

(PLEASE PRINT CLEARLY)



Insured Name (Last, First): _____

Please answer YES or NO to each of the following questions for yourself and each of your dependents. For each YES answer, please explain and provide details. **HAVE YOU OR ANY OF YOUR DEPENDENTS:**

1. Been admitted to a hospital or had surgery in the last five (5) years? YES NO
2. Within the past two years, have you, or has any dependent you are enrolling, been disabled and/or incurred medical costs exceeding \$5,000? YES NO
3. Been told that it may be necessary for you to be admitted to the hospital or have surgery **in the future**? YES NO
4. Been diagnosed with, treated for or had treatment for any of the following:

a. Heart or artery disease including heart attack, stroke, Aneurysm, arteriosclerosis, chest pain, rheumatic fever or Heart murmur?	<input type="checkbox"/> YES <input type="checkbox"/> NO	i. Diabetes, cystic fibrosis, albumin or sugar in the ii. Urine or other endocrine problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Hypertension?	<input type="checkbox"/> YES <input type="checkbox"/> NO	j. Asthma, emphysema, tuberculosis, pleurisy, or other diseases of the lungs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO	K. Paralysis, epilepsy, multiple sclerosis or other neuromuscular disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Diseases of the kidney, liver, gall bladder, pancreas or male/female organs, including venereal disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	l. Bleeding or blood disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO	m. Are you or any dependents now pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
f. AIDS, AIDS-related complex or other immune deficiency disorders, infections or chronic infection problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO	n. Are you or any dependents taking any medication (except contraceptives) that require a prescription by a physician?	<input type="checkbox"/> YES <input type="checkbox"/> NO
g. Alcohol or substance abuse, mental/nervous disorders?	<input type="checkbox"/> YES <input type="checkbox"/> NO	n. Any other medical condition that has not been disclosed above? *If so, describe in detail below:	<input type="checkbox"/> YES <input type="checkbox"/> NO
h. Ulcer, colitis, difficulty swallowing, stomach problems, hernia, or rectal problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

***If any YES box checked, please provide details concerning condition:**

APPLICANT/DEPENDENT(S): _____ DIAGNOSIS/CONDITION: _____

DATE OF DIAGNOSIS: _____ PRESCRIPTIONS: _____

WHERE TREATED: _____ TREATMENT: _____

ALREADY CURED: YES NO *If YES, please provide detail: _____

OTHER DETAILS: _____

Please attach additional pages if necessary

DECLARATION

1. I declare that I have answered all the questions truthfully and to the best of my knowledge. If this form has been completed on my behalf, I agree that I have satisfied myself as to the truthfulness of the responses given. I understand that any incorrect or incomplete answer or the concealment of any facts relevant to this insurance may invalidate this policy. I also understand that the insurer shall be entitled to retain all premiums paid during the policy year by virtue of a breach of this declaration.
2. I am also aware that I have a legal obligation to notify the insurer of any fact material to this insurance, which arises between the date of this declaration and the inception of this policy.
3. I agree to accept the insurer's standard form of policy for this type of insurance and have read and understood the important notice.

Signature of Primary Insured: _____

Date: _____



RESIDENCE VERIFICATION FORM

Visit us on the World-Wide-Web at: <http://www.tiecare.com>

26000 Towne Centre Drive Suite 100, Foothill Ranch, CA 92610
USA

I understand by signing this *Residence Verification Form* that I, _____, am certifying that
 I am I am not residing in the United States.

I understand that I must notify Global Benefits Group/TieCare International immediately of any change in my and/or my dependents residency. Failure to do so, may result in the denial of claims as well as the recovery of any claims already paid.

Please complete the *Residence Verification Form* for your dependents if residency different than yours.

I will submit an address change directly to your main office located at:

26000 Towne Centre Drive Suite 100, Foothill Ranch, CA 92610 USA

Phone: (949) 470-2100

Fax: (949) 457-3116

E-Mail: myhealth@tiecare.com

Street Address: _____

City, State: _____

Zip: _____

Country: _____

Phone Number: _____

Fax Number: _____

E-mail Address: _____

Are you planning trips to one of the following?

- | | | | |
|-------------------|-------------------------------|--|---------------------------|
| ◆ Canada: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |
| ◆ Hong-Kong: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |
| ◆ Singapore: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |
| ◆ Switzerland: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |
| ◆ United Kingdom: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |
| ◆ US: | <input type="checkbox"/> YES* | <input type="checkbox"/> NO - *how many: | *how long stay each time: |

Signature _____

Date _____

CLAIM REIMBURSEMENT

Members must choose one of the following options for Claims Reimbursements

1. Claims Reimbursement Card (MasterCard Debit Card.)

- Additional Card Benefits & Details - visit: www.claimssite.com
- Register for this option on the Website under CRC Card

***** Please attach a copy of a Government issued Photo ID with this application**

2. Direct Deposit to a U.S. Bank Account:

Name on the Account: _____

Bank Name: _____

Bank Address: _____

Routing #: _____

Account #: _____

Member Name _____

Signature _____ Date _____