

For company use
Policy number

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 plan

1 PERSONAL INFORMATION

Name of applicants (policyholder/dependents)	Relationship to policyholder	Marital status ⁽¹⁾	Date of birth Month/Day/Year	Sex	Weight	Height
First name: _____ M.I. _____ Last name: _____	Policyholder		____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs ____ kg <input type="radio"/> <input type="radio"/>	____ ft ____ m <input type="radio"/> <input type="radio"/>
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs ____ kg <input type="radio"/> <input type="radio"/>	____ ft ____ m <input type="radio"/> <input type="radio"/>
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs ____ kg <input type="radio"/> <input type="radio"/>	____ ft ____ m <input type="radio"/> <input type="radio"/>
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs ____ kg <input type="radio"/> <input type="radio"/>	____ ft ____ m <input type="radio"/> <input type="radio"/>

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 indicate the name of the college or university: _____
and provide copy of a certificate or affidavit from the college or university as evidence that they are full-time students.

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

⁽¹⁾S—single M—married DP—domestic partner D—divorced W—widow **Note:** An Attending Physician Statement (APS) is required for any person **age 65 and older**.

2 PRODUCT, PLAN AND ADDITIONAL COVERAGE REQUESTED

Please select product:
 Bupa Essential Care Bupa Secure Care Bupa Advantage Care: Worldwide Latin America Only⁽²⁾ Other _____

Please select deductible plan:

	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	5 <input type="radio"/>	6 <input type="radio"/>
In-country	0	1,000	2,000	5,000	10,000	20,000
Out-of-country	1,000	2,000	3,000	5,000	10,000	20,000

Bupa Critical Care

Please select deductible plan:

	1 <input type="radio"/>	2 <input type="radio"/>	3 <input type="radio"/>	4 <input type="radio"/>	5 <input type="radio"/>	6 <input type="radio"/>
In-country	2,000	3,500	5,000	10,000	20,000	50,000
Out-of-country	2,000	3,500	5,000	10,000	20,000	50,000

Renewals/additions: Worldwide Select Prestige Choice Deductible value: _____/_____/_____

Requested Effective Date of Coverage: ____/____/____ Additional coverage: Maternity complications ⁽³⁾ Transplant procedures ⁽⁴⁾

Other _____ If no additional coverage is selected, none will be granted.

⁽²⁾ Excludes Mexico • ⁽³⁾ Please fill out a Maternity Questionnaire • ⁽⁴⁾ 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: _____

Product name: _____

Deductible value: _____ Policy No.: _____

(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 OTHER INSURANCE INFORMATION (continued)

(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) Address

Home	_____		
ZIP code:	_____	City/State:	_____
		Country of residence:	_____
Mailing (if different from above)	_____		
ZIP code:	_____	City/State:	_____
		Country:	_____

(4.2) Residence/citizenship status

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

If the answer is "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

(4.3) Telephones, fax and e-mail

Home	Country code	Area code	Number	Work	Country code	Area code	Number
	_____	_____	_____		_____	_____	_____
Fax	Country code	Area code	Number	Cell	Country code	Area code	Number
	_____	_____	_____		_____	_____	_____
E-mail	_____						

5 BENEFICIARY INFORMATION

Names of beneficiaries			Relationship to policyholder
First name: _____	M.I. _____	_____	
Last name: _____			
First name: _____	M.I. _____	_____	
Last name: _____			

6 MEDICAL INFORMATION

(6.1) Family doctor(s)

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

(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.

Applicant	Type of exam	Date	Result:	If abnormal, please describe.
_____	_____	____/____/____ Month Day Year	Normal <input type="radio"/> Abnormal <input type="radio"/>	_____
_____	_____	____/____/____ Month Day Year	Normal <input type="radio"/> Abnormal <input type="radio"/>	_____
_____	_____	____/____/____ Month Day Year	Normal <input type="radio"/> Abnormal <input type="radio"/>	_____
_____	_____	____/____/____ Month Day Year	Normal <input type="radio"/> Abnormal <input type="radio"/>	_____

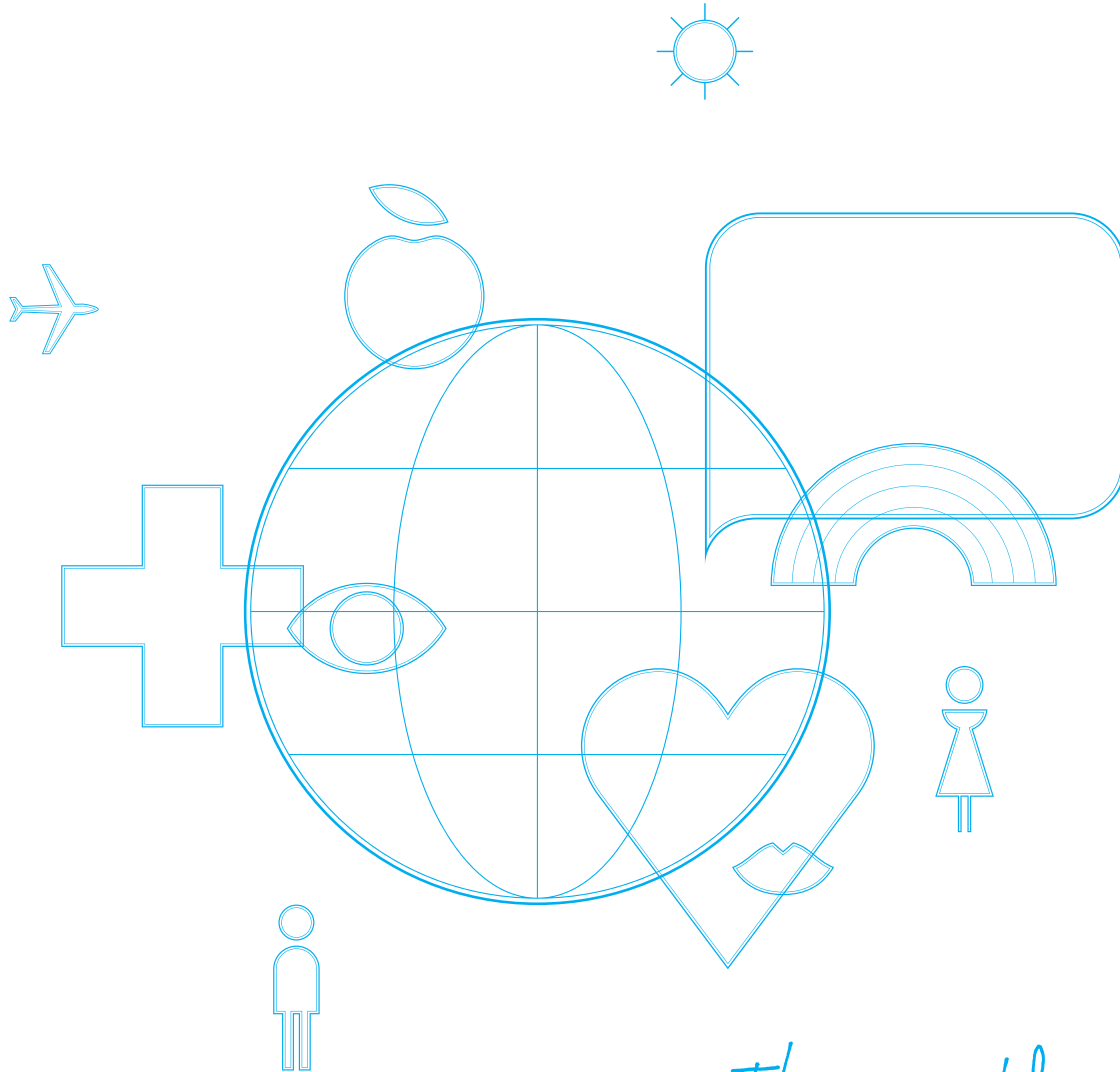
If more space is required, please use an additional sheet, signed and dated. If completed, please check here to confirm.

(6.3) Medical conditions

Has any applicant ever had...		Yes	No
a	infections?	<input type="radio"/>	<input type="radio"/>
b	vision, ear or hearing, nose or throat disorders?	<input type="radio"/>	<input type="radio"/>
c	seizures, migraine, paralysis or other neurological disorders?	<input type="radio"/>	<input type="radio"/>
d	heart disorders, circulatory disorders, high blood pressure, high cholesterol or high triglycerides?	<input type="radio"/>	<input type="radio"/>
e	allergies, asthma, bronchitis or other pulmonary disorders?	<input type="radio"/>	<input type="radio"/>
f	esophagus, stomach, intestines or pancreas diseases, hepatitis, other liver diseases or other digestive disorders?	<input type="radio"/>	<input type="radio"/>
g	kidney or urinary tract diseases?	<input type="radio"/>	<input type="radio"/>
h	spinal column problems, rheumatism, arthritis, gout, or other muscle, joint or bone disorders?	<input type="radio"/>	<input type="radio"/>
i	cancer or benign tumors?	<input type="radio"/>	<input type="radio"/>
j	anemia, leukemia/lymphoma or other blood disorders?	<input type="radio"/>	<input type="radio"/>
k	diabetes, thyroid gland disorders or other endocrine/hormonal disorders?	<input type="radio"/>	<input type="radio"/>
l	prostate disorders?	<input type="radio"/>	<input type="radio"/>
m	sexually transmitted or sexual organs diseases, or other reproductive disorders?	<input type="radio"/>	<input type="radio"/>
n	breast, ovaries/uterus disorders, or other gynecological disorders?	<input type="radio"/>	<input type="radio"/>
o	skin disorders?	<input type="radio"/>	<input type="radio"/>
p	congenital or hereditary disorders?	<input type="radio"/>	<input type="radio"/>
q	any other disease, disorder, illness, injury, accident, surgery, pending surgery or hospitalization not mentioned above?	<input type="radio"/>	<input type="radio"/>

If you have responded "Yes" to any of the above, please explain on the following page.

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