

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	____ ft m
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs kg	____ ft m
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs kg	____ ft m
First name: _____ M.I. _____ Last name: _____			____/____/____ Month Day Year	M <input type="radio"/> F <input type="radio"/>	____ lbs kg	____ ft m

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 Complete Care: Worldwide Latin America Only⁽²⁾ Bupa Diamond 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

Renewals/additions: P1 Diamond P1 Gold P1 Gold LA P1 Silver Silver Premier Care

Deductible value: _____/____/____

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

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

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

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7 ACKNOWLEDGEMENT AND AUTHORIZATION

Declaration

Claims and other benefits may not be payable if you do not fully disclose any material fact which could influence our assessment and acceptance of this application, and if there is any doubt as to whether any facts are material, you should disclose them. You are advised to keep a record of all information you supply to us in connection with this application, including letters.

If your health changes after the application has been signed but before Bupa Insurance Limited (Bupa) has approved the insurance, you must notify Bupa immediately of such change. You may be required to provide Bupa with medical reports in relation to this and any other pre-existing conditions.

In view of the following declaration, it is essential that complete information is supplied.

I declare that to the best of my knowledge and belief the information given by me is true and complete, and that, apart from the conditions fully disclosed to Bupa, I and any dependents under 18 to be insured on my policy are in excellent health and do not suffer or have suffered from any recurring illness or physical debility. If insurance for dental treatment is required, neither myself nor my dependents are under or about to undergo dental treatment.

I declare on my behalf and on my dependents' behalf, that I have read the policy conditions and this section of the Individual Health Insurance Application, and accept that the policy conditions together with the certificate of coverage and the Individual Health Insurance Application will represent the insurance contract with Bupa. I also declare that neither I nor my dependents under 18 are residents of the United States of America.

I confirm on my behalf and on my dependents' behalf, that I have read the Data Protection Notice below, and give explicit consent for Bupa to use my personal information and that of my dependents under the age of 18 in the manner and for the purposes stated.

Data Protection Notice

Purpose: Personal data collected about you and your dependents will be used by Bupa to process your claims, collect premium, provide reimbursements, administer your policy, and to detect and prevent fraud or improper claims. If Bupa does not accept your application, your information may be recorded by us.

Confidentiality: Bupa complies with applicable data protection legislation and medical confidentiality guidelines. All correspondence concerning your policy will be sent to the policyholder. All insured persons on the policy may have access to correspondence and other information sent by Bupa. Bupa uses third parties to process data on its behalf, and your data may be processed in or outside the European Union (EU). Bupa may exchange your information within the Bupa group and with your intermediary.

Medical information: Bupa may seek and exchange information about you and your dependents' health and treatment with those involved in your and your dependents' care (including your treating doctor and hospital) and their agents, and, if applicable, any person or organization who may be responsible for meeting your and your dependents' treatment expenses, or their agents, as Bupa deems necessary.

Telephone calls: In the interest of continuously improving our service to customers, your call will be recorded and may be monitored.

Research: Aggregated data and data which has been made anonymous, may be used by Bupa, or disclosed to others, for research or statistical purposes.

Fraud: Information, including recorded telephone calls, may be disclosed to others with a view to preventing or detecting fraudulent or improper claims.

Names and addresses: Bupa does not make the names and addresses of customers available to other organizations (except as stated above).

Keeping you informed: Bupa will, on occasion, keep you informed of its products and services which it considers may be of interest to you. Data protection legislation gives you the right to see documents and information Bupa has recorded about you.

Contact address: If you do not wish to receive information about our products and services, or would like to see a copy of the information we hold about you, please write to the Bupa Group Information Protection Manager at Bupa House, 15-19 Bloomsbury Way, London WC1A 2BA, England or at DataProtection@bupa.com.

11 PAYMENT INFORMATION (payment must be submitted with the application)

Policy type: Annual Semi-Annual Quarterly

Premium: US\$ _____
Optional rider(s): US\$ _____
Annual administrative fee: US\$ 75.00
Total amount: US\$ _____

Payment Method: Option 1

Cashier's check Check Money order Traveler's check Note: **DO NOT SEND CASH.**

Payment Method: Option 2

Wire transfer Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 063000021, Swift Number: PNBPU33

Payment Method: Option 3

ACH Bank Information: Bupa Worldwide Premium Trust, Wachovia Bank, Account Number: 2000037371881, ABA: 067006432

Payment Method: Option 4

Credit card Please provide the following information:

I, _____, authorize Bupa Worldwide Corporation

to charge my credit card:    

Credit card number _____ Expiration date _____ CVC _____
Month Year

Amount to charge US\$ _____

Identity card number _____ (For Venezuelan residents only)

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

Cardholder's phone number _____

Cardholder's signature _____

AUTOMATIC DEBIT FOR FUTURE RENEWALS Yes No

My signature on this document hereby authorizes Bupa Worldwide Corporation to debit the credit card and/or bank 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 and/or banking institution. In signing this document, I request and instruct the 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 policy is, for any reason, rejected or declined, I acknowledge that it will be my personal responsibility to immediately pay the premiums of my health insurance policy, or that my policy may lapse, be cancelled and/or terminated.

By signing, I authorize automatic deductions for future renewals.

Policyholder's signature

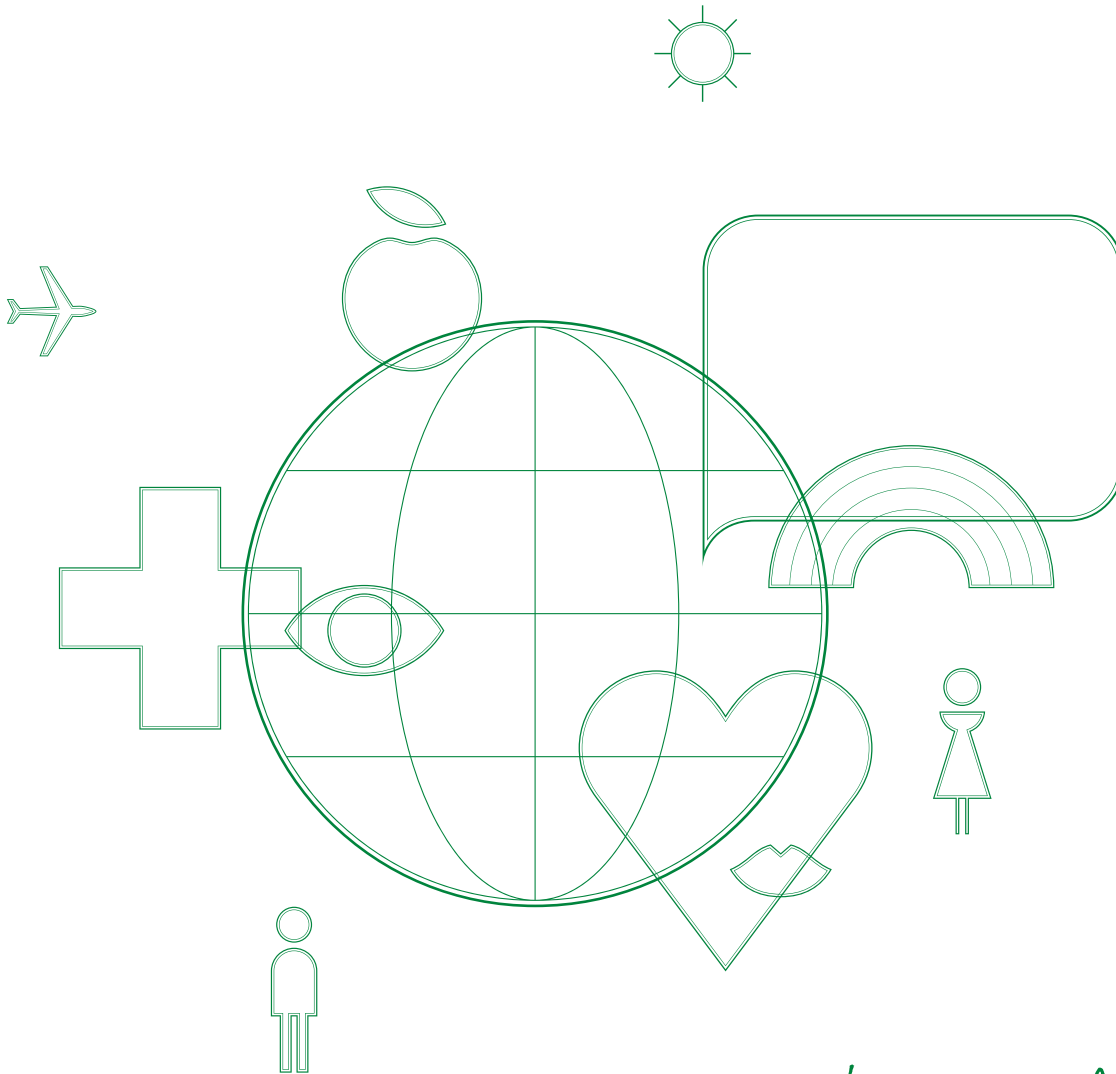
Cardholder's signature

____/____/____
Month Day Year
Date

Bupa Insurance Limited
Bupa House, 15-19 Bloomsbury Way
London WC1A 2BA, UK

Registered in England No. 3956433.
Bupa Insurance Limited is authorized
and regulated by the United Kingdom's
Financial Services Authority.

Administration:
7001 S.W. 97th Avenue
Miami, Florida 33173
Tel. +1 (305) 398 7400
Fax +1 (305) 275 8484
www.bupalatinamerica.com
bupa@bupalatinamerica.com



The world of Bupa

Bupa Diamond Care
Bupa Complete Care
Bupa Advantage Care
Bupa Secure Care
Bupa Essential Care
Bupa Critical Care
Bupa Corporate Care
Premier 1 Diamond
Premier 1 Gold
Premier 1 Silver
Silver
Premier Care