Application for **Individual Health Insurance**

This application is a legal document that must be read, completed in its entirety and signed by the main applicant and the agent.

The main applicant and his/her dependents must attach, along with this application, a copy of their passport or personal identification document (ID or equivalent). If any of the applicants has any existing medical condition, you must declare it in detail on pages 2-5 Section 5.

Applicants 65 years of age or older must provide the Attending Physician Statement properly completed and signed by their physician. If the information provided is incomplete or unsigned, it might cause delays in the underwriting process. VUMI® reserves the right to contact the applicant and/or his/her doctor if necessary.

New policy ◯ | Policy reinstatement ◯ | Dependent addition ◯ | Change of plan/option ◯

Section I. **Main Applicant** Information

1. Last name(s): | 2. First name: | 3. Middle initial:

4. Passport or ID number: | 5. Address:

6. City: | 7. State: | 8. Zip code: | 9. Country:

10. Occupation: | 11. Email address: | 12. Phone number (office or cell): | 13. Fax:

14. Gender: ◯ Male ◯ Female

15. Date of birth: M M / D D / Y Y Y Y

16. Marital status: ◯ Single ◯ Married ◯ Domestic Partner ◯ Divorced ◯ Widowed

17. Height: ◯ Meters ◯ Feet

18 Weight: ◯ Kilos ◯ Pounds

19. Nationality:

20. Are any of the dependent applicants currently living outside of the main applicant's country of residence? ◯ Yes ◯ No

21. Beneficiary full name (to receive payments on behalf of the Policyholder):

Section II. **Dependent** Information

Spouse or domestic partner, biological children, stepchildren, or legally adopted children by the main applicant or to whom the main applicant has been named legal guardian (children must be single)

DEPENDENT 1

1. Last name(s): | *2. First name:* | *3. Middle initial:*

4. Passport or ID number: | *5. Country of residence:* | *6. Relationship to the main applicant:* | *7. Date of birth:* M M / D D / Y Y Y Y

8. Gender: ◯ Male ◯ Female

9. Height: ◯ Meters ◯ Feet

10. Weight: ◯ Kilos ◯ Pounds

11. Is the dependent over 18 years old and a full-time student? ◯ Yes ◯ No

DEPENDENT 2

1. Last name(s): | *2. First name:* | *3. Middle initial:*

4. Passport or ID number: | *5. Country of residence:* | *6. Relationship to the main applicant:* | *7. Date of birth:* M M / D D / Y Y Y Y

8. Gender: ◯ Male ◯ Female

9. Height: ◯ Meters ◯ Feet

10. Weight: ◯ Kilos ◯ Pounds

11. Is the dependent over 18 years old and a full-time student? ◯ Yes ◯ No

Section II. **Dependent** Information

Spouse or domestic partner, biological children, stepchildren, or legally adopted children by the main applicant or to whom the main applicant has been named legal guardian (children must be single) (continued)

DEPENDENT 3

1. Last name(s): | *2. First name:* | *3. Middle initial:*

4. Passport or ID number: | *5. Country of residence:* | *6. Relationship to the main applicant:* | *7. Date of birth:* M M / D D / Y Y Y Y

8. Gender: ◯ Male ◯ Female

9. Height: ◯ Meters ◯ Feet

10. Weight: ◯ Kilos ◯ Pounds

11. Is the dependent over 18 years old and a full-time student? ◯ Yes ◯ No

If a dependent is over 18 years of age and a full-time student (minimum of twelve (12) credits per semester), a copy of a certificate or proof from the education institution must be attached.

If you need to include more dependents, ask your agent for the Dependent Information Annex and attach it to this application.

Section III. **Coverage**

1. Plan:

◯ Absolute VIP ◯ Universal VIP ◯ Special VIP ◯ Access VIP ◯ Access VIP Plus
◯ Senior VIP ◯ Direct VIP ◯ Optimum VIP ◯ Prime VIP

2. Deductible option:

US$

3. Additional coverage:

◯ Organ transplant

◯ Maternity and newborn complications

◯ Travel VIP Light

This rider offers coverage per person, per policy year. Please select the applicant(s) you would like to purchase this rider for:

◯ All the Applicants ◯ Main Applicant
◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3

Section IV. **Prior Coverage** Information

If you wish for the waiting period to be waived, please include a copy of the certificate of coverage and the payment receipt of the last 12 months of the prior coverage.

1. Do you have a health or any other medical coverage plan, with another company? If yes, please indicate: ◯ Yes ◯ No

1a. Name of the company: | *1b. Phone number:* + - -

1c. Plan: | *1d. Deductible and coverage amount:* | *1e. Policy number:* | *1f. Do you plan to keep the health insurance with the other company?* ◯ Yes ◯ No

2. Have you previously had medical insurance coverage with VUMI® or any of its affiliates? ◯ Yes ◯ No

2a. If you answered ***"Yes,"*** *please indicate your* VUMI® *policy number:*

3. Has any health insurance application been rejected, or accepted subject to restrictions or to a higher premium than the standard rates of the insurer for any of the applicants? ◯ Yes ◯ No

3a. If you answered ***"Yes,"*** *please explain:*

Section V. **Medical** Information

Part A: Medical Exams

1. Have any of the applicants had any medical exam, other than a routine examination in the past 5 years? If yes, please indicate: ◯ Yes ◯ No

1a. Full name of the applicant: | *1b. What type of exam?*

1c. What was the reason of the exam?

1d. Results of the exam:

1e. Are any of the applicants currently undergoing other exams to confirm a diagnosis? ◯ Yes ◯ No

2. Have any of the applicants had a pediatric, gynecological or routine exam in the last 5 years? If yes, please indicate: ◯ Yes ◯ No

MEDICAL EXAM 1

1. Full name of the applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please explain: ◯ Yes ◯ No

MEDICAL EXAM 2

1. Full name of the applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please explain: ◯ Yes ◯ No

MEDICAL EXAM 3

1. Full name of the applicant:

2. Type of examination:

3. Date: M M / D D / Y Y Y Y

4. Result:

5. Were there any follow-up tests? If yes, please explain: ◯ Yes ◯ No

3. Have any of the applicants had any medical consultations in the past 9 months? If yes, please indicate: ◯ Yes ◯ No

3a. Full name of the applicant:

3b. What type of medical consultation?

3c. Were there exams conducted as a result of this consultation? If yes, please detail which exams: ◯ Yes ◯ No

3d. Results of the exams:

4. Have any of the applicants ever suffered an accident? If yes, please indicate: ◯ Yes ◯ No

4a. Full name of the applicant:

4b. What type of accident? Is the applicant currently under treatment due to this accident? ◯ Yes ◯ No

4c. Are there any consequences in the applicant's health due to the accident suffered? If yes, please explain: ◯ Yes ◯ No

4d. Does the applicant use any orthopedic device or prosthesis? ◯ Yes ◯ No

Part B: Medication

1. Have any of the applicants been prescribed or are currently under treatment with any medication? If yes, please indicate: ◯ Yes ◯ No

MEDICAL TREATMENT 1

1. Full name of the applicant:

2. From: M M / D D / Y Y Y Y

3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 2

1. Full name of the applicant:

2. From: M M / D D / Y Y Y Y

3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

MEDICAL TREATMENT 3

1. Full name of the applicant:

2. From: M M / D D / Y Y Y Y

3. To: M M / D D / Y Y Y Y

4. Name of the medication, dose and frequency:

Part C: Medical Conditions

To the best of your knowledge and understanding, have any of the applicants received medical treatment, or had any diagnostic tests and/or suffered from any of the following diseases?

1 Nasal, vision, ear or throat disorders ◯ Yes ◯ No

2 Seizures, migraines, paralysis or other neurological disorders ◯ Yes ◯ No

3 Heart disorders, circulatory disorders, hypertension, high cholesterol or triglycerides ◯ Yes ◯ No

4 Allergies, asthma, bronchitis, pneumonia, lung disorder or other disorders of the respiratory system ◯ Yes ◯ No

5 Diseases of the esophagus, stomach, intestines, pancreas, gall bladder, hepatitis or other liver diseases as well as other disorders of the digestive system ◯ Yes ◯ No

6 Kidney or urinary tract diseases ◯ Yes ◯ No

7 Spine diseases or injuries, rheumatism, arthritis, gout or other muscular, joints or bone disorders ◯ Yes ◯ No

8 Cancer or benign tumors ◯ Yes ◯ No

9 Anemia, leukemia, lymphoma, coagulation disorders or other blood disorders ◯ Yes ◯ No

10 Diabetes, thyroid gland disorders or other endocrine/hormonal disorder ◯ Yes ◯ No

11 Skin diseases ◯ Yes ◯ No

12 Congenital or hereditary disorders ◯ Yes ◯ No

13 Sexually transmitted diseases or sexual organs or other reproductive system disorder ◯ Yes ◯ No

14 Prostate diseases ◯ Yes ◯ No

15 Breast, ovaries, uterus or other gynecological disorders ◯ Yes ◯ No

16 Is the main applicant or any of the dependents currently pregnant? (if yes, please provide the expected due date): ◯ Yes ◯ No

M M / D D / Y Y Y Y

17 Has the main applicant or any of the dependents been pregnant? (if yes, please complete): ◯ Yes ◯ No
17a. Number of pregnancies: *17b. Deliveries:* *17c. C-sections:* *17d. Abortions:*

18 Pregnancy or delivery complications, multiple pregnancy, or a child with a congenital or hereditary condition (if yes, provide details of the case in Part D) ◯ Yes ◯ No

19 Have any of the applicants had any other illness, condition, injury, accident, surgery, medical consultation, diagnosis, involuntary weight loss or hospitalization not listed above? ◯ Yes ◯ No

Part D: Explanation of Medical Conditions (declared in Part C of this application)

MEDICAL CONDITION 1

1. Number: *2. Full name of the applicant:* *3. Condition, illness or injury:*

4. From: M M / D D / Y Y Y Y *5. To:* M M / D D / Y Y Y Y *6. Name of the physician:*

7. Physician's phone number: + - - *8. Treatment:* *9. Result of the treatment:*

10. Current status of the condition, illness or injury (ex.: if you are in treatment, the condition was resolved or is under control):

MEDICAL CONDITION 2

1. Number: *2. Full name of the applicant:* *3. Condition, illness or injury:*

4. From: M M / D D / Y Y Y Y *5. To:* M M / D D / Y Y Y Y *6. Name of the physician:*

7. Physician's phone number: + - - *8. Treatment:* *9. Result of the treatment:*

10. Current status of the condition, illness or injury (ex.: if you are in treatment, the condition was resolved or is under control):

MEDICAL CONDITION 3

1. Number: *2. Full name of the applicant:* *3. Condition, illness or injury:*

4. From: M M / D D / Y Y Y Y *5. To:* M M / D D / Y Y Y Y *6. Name of the physician:*

7. Physician's phone number: + - - *8. Treatment:* *9. Result of the treatment:*

10. Current status of the condition, illness or injury (ex.: if you are in treatment, the condition was resolved or is under control):

Part E: Habits

1. Do any of the applicants use or have used nicotine products, alcoholic beverages, legal or illegal narcotics, or illegal drugs? If yes, please indicate: ◯ Yes ◯ No

TYPE OF HABIT 1

1. Full name of the applicant: *2. Product and amount consumed per day:* *3. From - To (month/year):* M M / Y Y - M M / Y Y

TYPE OF HABIT 2

1. Full name of the applicant: *2. Product and amount consumed per day:* *3. From - To (month/year):* M M / Y Y - M M / Y Y

TYPE OF HABIT 3

1. Full name of the applicant: *2. Product and amount consumed per day:* *3. From - To (month/year):* M M / Y Y - M M / Y Y

Section V. **Medical** Information (continued)

Any exam, treatment, and/or consultation carried out by the main applicant or any of his/her dependents before submitting the application, or during the underwriting process (if applicable), or the approval process, until the effective date of the policy, must be informed to VUMI® Group, I.I. in order to add this information to the application. Likewise, any accident and/or symptom that occurred or manifested during this period, must be informed to the company in order to take this new information into consideration for the approval of the coverage and the issuance of the corresponding documents.

Failure to provide this information will be considered as an act of bad faith when accepting the policy's contractual obligations and VUMI® Group, I.I. reserves the right to reject the application or contest the validity of the approved policy.

Section VI. **Family** History

1. Do any of the applicants have a family history of diabetes, hypertension, heart disorders, cancer or congenital or hereditary diseases? If yes, please indicate: ◯ Yes ◯ No

FAMILY HISTORY 1

1. Full name of the applicant:	*2. Relationship:*	*3. Disease:*

FAMILY HISTORY 2

1. Full name of the applicant:	*2. Relationship:*	*3. Disease:*

2. If any of the dependents is adopted, do you know his/her family medical history? If yes, please indicate: ◯ Yes ◯ No

FAMILY HISTORY 1

1. Full name of the applicant:	*2. Relationship:*	*3. Disease:*

FAMILY HISTORY 2

1. Full name of the applicant:	*2. Relationship:*	*3. Disease:*

Section VII. **Claims** Reimbursement Method

1. Please indicate how you would like to receive claim reimbursement payments. We remind you that bank transfers are the fastest and safest method for this purpose: ◯ Check ◯ Bank Transfer

2. Do you wish for the claim reimbursement payments to be transferred to the bank account described in section X? If you answered **"No"**, please provide the corresponding information below: ◯ Yes ◯ No

FOR BANK TRANSFER

1. Bank account holder's full name:	*2. Country:*	*3. Bank name:*

4. IBAN or account number:	*5. SWIFT code:*	*6. ACH/RT (only for Bank of America):*	*7. ABA:*

Section VIII. **Acknowledgement** and Authorizations

I have read, fully understand, and freely and voluntarily sign as my acceptance of the contents of this application. I declare that the personal and medical information I have included in this application is true, complete and accurate, and I affirm that I have not omitted, concealed, modified or altered this information. I am fully aware and accept that in case of any omission, concealment, modification or alteration of the information declared in this application, or information that has not been subsequently declared up until the effective date of the policy, will be considered an act of bad faith when accepting my contractual obligations, and may cause claims to be denied, or put on hold until the beneficiary(ies) complete the required information, and the policy to be modified, rescinded or canceled, for which a written communication from VUMI® Group, I.I. will suffice. VUMI® Group, I.I. reserves the right of taking legal and administrative action in case of any indemnities.

I understand the Company reserves the right to reject this application based on the information I submitted regarding my or any of the applicants' residence or health, or for any other reasons the Company considers relevant. This application is valid for sixty (60) days from the day it was signed. If I want to withdraw my application from the underwriting process, I will have to send a written notification to VUMI® Group, I.I. or its authorized representatives within fifteen (15) days of the subscription of the application.

I understand I am applying for international medical insurance coverage that may not provide mandatory benefits required by regulations of my country of residence or any other jurisdictions. I will have fifteen (15) days to review the coverage offered by the Company, if I am not satisfied, I can return the policy to the Company and receive a reimbursement of the net premium paid.

Authorization to collect and disclose health information of the applicants

I hereby authorize VUMI® or VUMI® Group, I.I., its subsidiaries and any affiliated companies or its designated representatives to request my medical records and/or those of my dependents, as well as any prescription medication history and any other medical or pharmaceutical information to be considered in the underwriting process regarding the application for health insurance coverage for myself and my dependents.

I authorize any physician, hospital, laboratory, pharmacy or other medical provider, insurance company, if I had a prior or another medical coverage, government agencies, employee or benefit plan administrator, organization from whom I represent and have legal authorization, and person, including any family member who has medical records or knowledge of me and/or my dependents or our health, to disclose such information to VUMI® or VUMI® Group, I.I. or its designated representatives. Likewise, I hereby authorize VUMI® or VUMI® Group, I.I., its subsidiaries and any affiliated companies or its designated representatives to disclose to my insurance agent, affiliates and successors the terms of my policy, my certificate of coverage and other insurance documents, payment information, claims, reimbursement requests and medical records that may contain protected health information that will enable them to address my questions and facilitate interaction regarding my insurance coverage, payments and claims. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal laws of the United States governing privacy and confidentiality.

The existence of any information and documentation described above shall be disclosed with this application. I understand that VUMI® will use this information to: 1) assess the risk of application for coverage and make decisions about eligibility, risk rating, policy issuance and registration of all applicants; 2) processing a claim and provide benefits; 3) administer coverage; and 4) conduct other insurance operations according to applicable law.

A copy of this authorization will be considered as valid as the original. I understand that the ability of VUMI® to assess coverage is based on receiving all necessary personal and health information.

Privacy

All personal medical information will be treated as confidential by VUMI® Group, I.I., its affiliated companies or its designated representatives. The Company complies with the Data Protection legislation and the confidentiality of the medical information rules and regulations. The Company will not share any medical information, unless an authorization to do so exists, whether by the patient, his/her legal representative(s) or the law.

Arbitration and legal actions

All claims and disagreements arising under this Application, or related with it, are to be settled by binding arbitration in New York, New York, USA.

The arbitration shall be confidential pursuant to the JAMS International Arbitration Rules. If the arbitration were to result in the receipt of compensation by either party, it may be subject to confirmation by a court of competent jurisdiction.

Governing Law

The parties agree to grant to the State and Federal courts located in the borough of Manhattan, County of New York, State of New York (or if there is exclusive federal jurisdiction), exclusive jurisdiction and venue over any disputes, action or proceedings arising out of or in connection with this contract involving the parties, and the parties hereby consent to the jurisdiction of such courts. _____. (initials)

I, _____on this ____/____/202___, do hereby consent and acknowledge my express agreement to the terms set forth in the insurance application regarding arbitration and governing jurisdiction of any claims I may have during the existence of the policy I am applying for, and any subsequent changes in the policy. I understand that this consent shall remain in force from this time forward.

1. Full name of the main applicant:	2. Main applicant's signature:	3. Date:
	X.....	M M / D D / Y Y Y Y
4. Full name of the spouse:	5. Spouse's signature:	6. Date:
	X.....	M M / D D / Y Y Y Y

TO BE COMPLETED BY THE AGENT

As Agent, I accept full responsibility for submitting this application, all premiums collected and the delivery of the policy when issued. To the best of my knowledge, I do not know of the existence of any condition that has not been disclosed in this application that could affect the insurability of the proposed insureds.

7. Full name/code of the agent:	8. Agent's signature:	9. Date:
	X.....	M M / D D / Y Y Y Y

Section IX. **Emergency Coverage** for Accidents

This benefit is available to all applicants since the reception of the application* until the policy is approved.

Requirements

*Complete signed application (with all the necessary information to be approved according to the Company's underwriting guidelines) and total premium payment, according to the payment frequency.

Benefit

Up to thirty thousand dollars (US$30,000).

Term

Maximum of sixty (60) days or until the effective date of the requested policy, whichever occurs first.

This benefit covers the expenses for injuries caused by accidents that occur during the underwriting process and is subject to the terms and conditions of the policy and to the application of the deductible of the chosen plan/option.

The exemption for the elimination of deductible in case of a serious accident benefit does not apply for this temporary benefit. Payments will be made via reimbursement once the policy is approved. This benefit is available when adding new insureds to an existing policy. The accident covered under this benefit and/or its consequences will not affect the approval of the application.

Section X. **Payment** Information

1. Full name of the main applicant:

2. Policy number:

3. Payment frequency:

- ◯ Annual
- ◯ Semi-annual
- ◯ Quarterly

Health Insurance premium amount	US$
Expat Rate	US$
Optional additional coverage	US$
Annual administrative fee	US$
Total amount	US$

DO NOT SEND CASH. Payment must be issued to VUMI® Group, I.I.

Payment method OPTION 1:

◯ Check ◯ Bank Transfer **For payments via bank transfer, use the following information:**

Beneficiary:	VUMI® Group, I.I.	**Account number:**	1511025379
Bank:	Texas Capital Bank, N. A.	**ABA:**	111017979
Address:	Richardson, Texas 75082	**SWIFT code:**	TXCBUS44

Section X. **Payment** Information

(continued)

Payment method OPTION 2:

Please provide the following information:

I, , authorize VUMI® Group, I.I., to charge my:

◯ Credit Card

◯ MasterCard ◯ VISA ◯ AMERICAN EXPRESS ◯ DISCOVER

Credit card number:

Expiration date: M M / Y Y Y Y CVC: Amount to charge: US$

Cardholder's / bank account holder's phone number:

+ - -

◯ Bank Account (U.S. banks only)

Bank account holder's full name:

Account number:

ABA: Amount to charge: US$

Cardholder's / bank account holder's phone number:

+ - -

Cardholder's / bank account holder's address (where statement is received):

Automatic debit for future renewals: ◯ Yes ◯ No

By signing this document, I authorize VUMI® Group, I.I. to automatically debit the credit card and/or bank account mentioned above, to pay the premium of my VUMI® health insurance policy.

I understand that if there is any change in my VUMI® insurance policy or in the annual rates, the premium amount due may change.

By signing this document, I request and instruct the relevant institution to allow VUMI® Group, I.I. to directly debit my account to pay the insurance premium unless otherwise stated in writing. In the event that a direct debit is, for any reason, rejected or denied, I accept that I have a personal responsibility to pay my insurance premiums immediately to prevent the policy from expiring.

I also understand that a true and correct copy of this document will be sent to my bank or credit card company to process these payments.

By signing below, I authorize automatic deductions for future renewal payments.

Cardholder's / bank account holder's signature:

X .....