



International Health Insurance Application

An Allnation General Agent:
 Global Insurance Net
 7700 N. Kendall Drive, Ste. 503
 Miami, Florida 33156 USA
 Telephone: 305.274.0284
 Fax: 305.675.6134

A. Instructions

1. Please **print** or **type**. Read all the agreement terms carefully and complete all sections. If the space provided is insufficient, please attach additional sheet(s) of paper. **Sign** the application.
2. Enter the name of only those family members currently eligible.
3. Enclose payment with the application.
4. All check payments should be made payable to: Allnation Insurance Company.
5. Return pages 1-4 to **Global Insurance Net**.
6. Separate page 5 and leave with applicant.

B. Coverage Selection Information

Classic Gold
 Select Silver
 Optional Dental Cover (\$384 Annual or \$198 Semi-Annual, per person)
 Critical Illness
 Health coverage selected for:
 Self
 Spouse
 Children
 How many? _____
 Add Dependent
 Deductible Selected: \$ _____
 Premium Payment: Annually \$ _____
 Semi-Annually: \$ _____
 Policy Number: _____

C. Personal Information

Name:

 Last Name First Name Middle Jr., Sr.

Residential Address:

 Street and Number

 City State Country Zip Code

Home Phone: () _____

Mailing Address *(if different from above):*

 Street and Number

 City State Country Zip Code

- Male Married Divorced Active Employee Retired
 Female Single Widowed Fulltime Student Self-Employed

For Office Use Only

Date Received	Effective Date	First Yr. Rates: Principal	Spouse	No. of Children

D. Employment Status

Company/School Name: _____
 Occupation: _____
 Address: _____
Street and Number

City State Country Zip Code
 Business Phone: () _____ Fax: () _____
 E-Mail Address: _____
 Position: _____ Years there: _____ Are you a frequent traveler? Yes No

Please complete the information below for both you and your dependents. NOTE: Attach another page for additional Dependents

Print full name of applicant and other members of family.	Nationality	Passport Number	Relationship to Applicant	Sex: M / F	Date of Birth Mo., Day, Yr.	Age	Height Ft., In.	Weight Lbs.
					/ /			
					/ /			
					/ /			
					/ /			

E. Other Health Care Coverage

Do you (or any dependents listed on this application) have other medical insurance coverage? Yes No
 If **Yes**, provide name of other medical insurance company: _____
 Telephone: () _____
 Who is insured? Yourself Spouse Dependent Children Policy Number: _____
 Are you applying for the Allnation coverage indicated in Section B above in order to replace another sickness and accident or other health policy that you presently have in effect? Yes No

F. Health Related Information. False or incomplete information will void health coverage.

- Do you (or any dependents listed on this application) have a family physician? Yes No If **Yes**, complete "a", below.
 - Names and complete addresses of your family physicians: _____

- Is each person for whom application is being made in good health and without any known need for hospital or medical care? Yes No If **No**, give details:

Name of person(s): _____
 Type of illness: _____
 Date(s) of treatment: _____
 Names and complete of addresses of attending physicians: _____

Please provide a full explanation of any condition checked below. (Attach separate sheet(s) of paper if necessary.)

3. Do you (or any person applying for this coverage) have, or have you (or any person applying for this coverage) ever had, been treated for, or experienced symptoms of:
- a. Tuberculosis, asthma, allergies, disease of lungs, respiratory system, shortness of breath, wheezing, blood-tinged sputum? Yes No
 - b. High or low blood pressure, anemia, disease of the heart or circulatory system, chest pain or pressure, dizziness/vertigo, numbness or tingling of extremities?..... Yes No
 - c. Disease of digestive system, stomach, liver, gall bladder, hemorrhoids, rectal trouble, chronic heartburn/indigestion, ulcer?..... Yes No
 - d. Paralysis, convulsions, disease of the brain or nervous system, Attention Deficit Disorder (ADD), chronic headaches, migraine headaches, double or blurred vision, weakness of any extremity? Yes No
 - e. Disease of urinary system, kidneys, ureters, bladder, prostate, urethra, frequent or painful urination, difficult urination or bloody urine?..... Yes No
 - f. Rheumatism, arthritis, gout, disease of the muscles, bones, joints, swollen/painful joints, chronic back pain, joint surgery?..... Yes No
 - g. Any deformity, skin disorder, abnormal growth, spinal curvature, lameness, loss of limb, back disorder? Yes No
 - h. Hernia, rupture, venereal disease, cancer, tumor, diabetes, thyroid, epilepsy, nervous or endocrine disorder? Yes No
 - i. Any disorders of the breasts, uterus, tubes, ovaries, endometriosis, irregular or excessive menses, absence of menses? Yes No
 - j. Disorder of the immune system, Acquired Immune Deficiency Syndrome (AIDS) and/or AIDS-related complex (ARC)?..... Yes No
 - k. Use of tobacco, alcohol or any habit-forming or recreational drugs? Yes No
 - l. Any illness, disease or physical impairment not mentioned in the questions above? Yes No
4. Have you (or any person applying for coverage) ever had counseling and/or treatment for a psychological or psychiatric condition? Yes No
5. Are you (or any person applying for coverage) taking any prescribed medication, under medical treatment or presently pregnant?..... Yes No
6. Has any person applying for coverage consulted, been treated by any physician or practitioner, had an operation or been a patient in a hospital or similar institution for a condition other than those named in #3, above? If **Yes**, please complete the following: Yes No

Name of Person Treated	Place of Treatment	Date of Treatment MM DD YY	Condition Treated
		/ /	
		/ /	
		/ /	

G. Method of Payment (check one)

Check payable to: *Allnation Insurance Company* VISA MasterCard American Express Discover Diner's Club

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: ____ / ____ 3 Digit Security Code: _____ (Last 3 digits on the back of the credit card)

Amount: \$ _____

Print Name (as it appears on credit card): _____

Cardholder's Signature: _____

H. Conditions of Coverage. I understand and agree that:

1. All applications are subject to acceptance and approval by Allnation (the Company). The Company will determine eligibility after it receives my application with payment and any necessary medical records or documentation. If Allnation approves my application, the Company will notify me of the effective date of my coverage.
2. All representations and information supplied by me are true, complete and correct and are given to induce the issuance of the Contract. The Contract will be void if any statement or representation made herein is false or incomplete.
3. All terms and conditions of this coverage are specified in the Allnation International Health Insurance Contract, which shall be issued to me upon approval of the application. The application and all representations and statements made herein will be considered a part of the Contract.
4. I understand that Allnation may need medical information to determine eligibility for coverage and benefits. I authorize any hospital, skilled nursing facility, health maintenance organization, pharmacy, physician, dentist, pharmacists, professional review organization and any and all other providers of service to disclose and furnish to Allnation any and all records relating to the Insureds, including a complete diagnosis and all medical information for as long as the policy is in effect.
5. I authorize Allnation to furnish to any Utilization Review Organization or to any other insurer or administrator, or to any health maintenance organization, or to any law enforcement agency, any and all medical records and information relating to the Insureds as deemed necessary by Allnation for the administration of coverage.

I am submitting this application as agent for the insured applying for coverage. I accept full responsibility for remitting all collected premiums and for the delivery of the policy to the insured when and if issued. I do not know of any physical, moral or employment problem not listed in this application.

Premium: Annual Semi-Annual \$ _____

Make check payable to: *Allnation Insurance Company*

Producing Agent's Name (Print): _____

Producing Agent's Number: _____

Producing Agent's Signature: _____ Date: _____

General Agent's Name (Print): **Carlos Perez / Global Insurance Net**

General Agent's Number: **2087**

I. Signature of Applicant or Designated Representative (Parent, spouse, employer or legal representative)

(on behalf of him/herself and all others applying for coverage)

Date