REGENT International

Medical Insurance Application Form

FOR COMPANY USE ONLY	
Policy Number	
Effective Date	

I - PERSONAL INFORMATION - PROPOSED PRINCIPAL INSURED OR LEGAL GUARDIAN

Full Name — Name (s) | 1st Last Name | 2nd Last Name — Date of Birth (dd/mm/yyyy)

Civil Status	Gender	Smoker	Height	Weight	Official Identification or Passport #
☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Domestic Partner	☐ F ☐ M	☐ No ☐ Yes	☐ Ft ☐ M	☐ Kg ☐ Lb	

Permanent Residential Address

Street and Number | City | State | Country | Postal Code

Email Address	Mobile Telephone	Residential Telephone

Mailing Address ☐ Same as Residential Address (This address will be used to send all policy documents & correspondence)

Street and Number | City | State | Country | Postal Code

Employment Information ☐ Business Owner ☐ Employee ☐ Self Employed ☐ Housewife ☐ Student* ☐ Other:

Employer Name	Work Phone Number	Occupation	Annual Income (USD)
			$

Employer Address

Street and Number | City | State | Country | Postal Code

* Is Full-Time student?: ☐ Yes ☐ No If the answer is affirmative, fill in the information below:

College Name	City	Country

II - PERSONAL INFORMATION - PROPOSED INSUREDS

SPOUSE OR DOMESTIC PARTNER

Full Name — Name (s) | 1st Last Name | 2nd Last Name — Date of Birth (dd/mm/yyyy)

Civil Status	Gender	Smoker	Height	Weight	Official Identification or Passport #
☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Domestic Partner	☐ F ☐ M	☐ No ☐ Yes	☐ Ft ☐ M	☐ Kg ☐ Lb	

Permanent Residential Address ☐ Same as the Proposed Principal Insured

Street and Number | City | State | Country | Postal Code

Email Address	Mobile Telephone	Residential Telephone

Employment Information ☐ Business Owner ☐ Employee ☐ Self Employed ☐ Housewife ☐ Student* ☐ Other:

Employer Name	Work Phone Number	Occupation	Annual Income (USD)
			$

Employer Address

Street and Number | City | State | Country | Postal Code

* Is Full-Time student?: ☐ Yes ☐ No If the answer is affirmative, fill in the information below:

College Name	City	Country

CHILDREN(S) (Unmarried children up to 23 years may be registered as dependents in the Parent's Declaration)

	Name(s)	Last Name	Identification #	Gender	Date of Birth (dd/mm/yyyy)	Height ☐ Ft ☐ M	Weight ☐ Kg ☐ Lb	Country of Residence
Child #1				☐ F ☐ M				
Child #2				☐ F ☐ M				
Child #3				☐ F ☐ M				
Child #4				☐ F ☐ M				

If you need more space, or if the address of any Proposed Insured differs from the Proposed Principal Insured or Legal Guardian address, indicate in Section VIII: name, address, telephone, and reason.

Additional Information for Dependent Children

Full Name	College Name	Full Time Student	City / Country
		☐ Y ☐ N	
		☐ Y ☐ N	
		☐ Y ☐ N	

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III - MEDICAL INFORMATION (If you don't have a doctor, write **"None"**)

	Physician's Full Name / Clinic or Hospital	Physician's Specialty (if apply)	Address	Telephone or Email
Principal				
Spouse				
Child #1				
Child #2				
Child #3				
Child #4				

Do any of the proposed insureds herein have had or have health, cancer or personal accident coverage with us or another insurer?

☐ Yes ☐ No If **affirmative**, provide requested information.

*and include **copy** of Certificate of Coverage and Payment Receipts, **or** Renewal Notice.*

Name of Insurer	Policy Number	Renewal Date (dd/mm/yyyy)

Details

Is this application intended to replace any other existing or canceled coverage?

☐ Yes ☐ No If **affirmative** answer, offer details.

Details

IV – DESIGNATION OF BASIC LIFE INSURANCE BENEFICIARIES, IF APPLY

PROPOSED PRINCIPAL INSURED

Full Name	Relationship	Date of Birth (dd/mm/yyyy)	Designated Percent

DEPENDENT SPOUSE OR DOMESTIC PARTNER

Full Name	Relationship	Date of Birth (dd/mm/yyyy)	Designated Percent

V - PAYMENT INFORMATION

MODAL PAYMENT (Charges apply for modal payments: Semi-Annual: 0.52 | Quarterly: 0.27 | Monthly: 0.09)

☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly

(Monthly Payments, only available through recurring payments by Credit Card or Bank Debit.)

METHOD OF PAYMENT (The Company does not accept the charges imposed by the Financial Institution of your choice.)

☐ Credit Card* ☐ Bank Debit* ☐ Check ☐ Transfer

* Payments by Credit Card or Bank Debit, must complete the information below

PAYOR | If the Payer is not the Proposed Insured or the Owner

Full Name	Relationship	Official Identification or Passport #

☐ I as the payer and holder of the credit card provided herein, I **AUTHORISE** and **ACCEPT** that REDBRIDGE and its Administrators Regent International debits the payments due for the initial premium, in connection with the policy granted by this online insurance application, subject to change due to surcharge, limitation and / or exclusion. I understand that if there is any change, the Company will communicate the exact amount to pay, and in case the transaction is rejected, it is my responsibility to present a payment alternative to activate the policy.

☐ I **AUTHORISE** and **ACCEPT** that subsequent modal and renewal premiums are debited from the same card and this authorisation will be considered valid while the policy remains in effect, or until I submit a written cancellation request to the Company.

CREDIT CARD		**BANK DEBIT** (Add picture of voided check)	
Cardholder Name (As it appears on card)	Expiration Date (MM/AAAA)	Account Name	Bank Account Number
Card Number	Verification Code (CVV)	Bank Name	Routing Number (ABA)
Billing Address	Daytime Phone	Bank Address	Daytime Phone

VI - PLAN DETAILS (USD)

Plan Name			
Benefit Amount			
Deductible (in L.A.)		Deductible (out of L.A.)	
Optional Benefits (If apply)			

PREMIUM SUMMARY (USD)	
Annual Premium	
Optional Benefits Premium	
Policy Fee	
Total Annual Premium	
Modal Premium	
Amount with Application	

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VII – DECLARATION OF INSURABILITY (All answers are mandatory)

If **affirmative** answer for any person in this declaration, circle the specific condition and offer details below:	YES	NO
1- Have you, or any proposed insured included in this application ever been declined, had coverage postponed, or classified as a non-standard risk; or has your insurance coverage modified, cancelled, non-renewed, for either life, health or similar type of insurance, by any other insurance carrier?	☐	☐
2- Have you, or any other proposed insured included in this application, been examined, diagnosed, hospitalized, or have received medical recommendation to perform diagnostic tests, treatment and/or surgery for any of the following conditions or disorders?		
a. Eyesight problems, glaucoma, blindness, cataracts, ear problems, loss of hearing, dizziness, throat, nose, deviated nasal septum or deformity;	☐	☐
b. Mental, behavioral, emotional or eating disorder, anxiety, depression, psychosis, bipolar, psychological or psychiatric counseling or therapy, epilepsy, convulsions, migraines, multiple sclerosis, muscular dystrophy, paralysis, poliomyelitis, or any other disorder of the neurological or central nervous systems;	☐	☐
c. Hypertension, high cholesterol, triglycerides, heart attack, arrhythmia, angina, chest pain, murmur, stroke, transient ischemic attack (TIA), aneurysm, varicose veins, blood clot, or any other disorder of the cardiovascular or circulatory systems;	☐	☐
d. Asthma, emphysema, bronchitis, sinusitis, allergies, pneumonia, apnea, chronic cough, tuberculosis, or any other disorder of the respiratory or pulmonary systems;	☐	☐
e. Hepatitis, pancreatitis, chronic diarrhea, ulcerative colitis, hiatal hernia, gastritis, peptic ulcers, esophagitis, hemorrhoids, rectum or intestine disorder, parasitic disease, gallbladder, liver, kidney, urinary bladder, or any other disorder of the gastrointestinal or urinary systems;	☐	☐
f. Rheumatoid arthritis, arthritis (any type), rheumatism, rheumatic fever, osteoporosis, gout, temporomandibular joint syndrome (TMJ), any amputation, deformity or incapacity, back pain, herniated disc(s), or any other disorder of the bones, muscles and joints (including replacements), bone marrow, connective tissue, lupus (any type), or any other disorder of the immunological or skeletal systems;	☐	☐
g. Cancer, tumor, cyst or growth, keratosis, anemia (any type), leukemia, hemophilia, blood infection, enlarged lymph node, or any other disorder of the lymphatic or hematological systems;	☐	☐
h. Dermatitis, psoriasis, parasitic disease such as Chagas disease, or any other disorder of the skin;	☐	☐
i. Diabetes, pre-diabetes, sugar in the urine, insufficiency of the pituitary or adrenal gland, thyroid, or any other disorder of the endocrine system;	☐	☐
j. If a **female**: mammary glands, breast implants or prostheses, conditions related to breast implants, endometriosis, irregular menstruations, test with abnormal results, infertility problems/treatments, or any other disorder with the internal/external genitals. If a **male**: mammary gland, prostate, PSA elevated, sexual dysfunction, any conditions related to penile implant, or any other disorder with the internal/external genitals;	☐	☐
k. If a **female**, are you pregnant? Indicate date of last menstruation _____ (dd/mm/yyyy). Is this pregnancy resulting from a fertility treatment? Do you have any history or anticipate any complications with this pregnancy?	☐	☐
l. Congenital conditions, hereditary illnesses, genetic mutations, or any malformation?	☐	☐
m. Acquired Immune Deficiency Syndrome (AIDS), or HIV Positive, AIDS Related Complex (ARC), opportunistic diseases related to AIDS, any other disorder of the immune system, or sexually transmitted diseases, including herpes and human papilloma virus;	☐	☐
n. Any other disorder, physiological or mental, lesion, accident or incapacity not previously mentioned in this section.	☐	☐
3- During the past **ten (10) years**, have you or any proposed insured included in this Declaration:		
a. have had a routine physical check-up or a medical exam?	☐	☐
b. have had any abnormal results during a routine physical check-up or medical exam?	☐	☐
c. have been recommended, or had performed any diagnostic test such as x-rays, electrocardiogram, electroencephalogram, laboratory tests or any other exam or diagnostic procedure?	☐	☐
d. have been hospitalized in a medical center, clinic, hospital, sanatorium, rehabilitation center, or any other similar facility?	☐	☐
e. have been under a medical treatment, physical or mental?	☐	☐
f. have had any surgical procedure performed as an outpatient or inpatient?	☐	☐
g. have been advised, recommended or prescribed any potential surgical procedure and/or treatment that has not been performed within the last twelve (12) months, or that have been performed and you are waiting for the results?	☐	☐
h. have received any type of treatment for alcoholism, drug addiction, and/or any other substance or addiction?	☐	☐
i. have used tobacco (any of its forms) within the last twelve (12) months? Indicate amount per day _____. If you quit: _____ (dd/mm/yyyy).	☐	☐
4- Do you or any proposed insured included in this application, have an immediate family member (father/mother/siblings) with a history of cancer, epilepsy, stroke, diabetes, hypertension, cardiovascular o circulatory conditions, or any other hereditary or congenital condition?	☐	☐
5- In the last 45 days, you or any other person included in this Declaration:		
a. have traveled inside or outside your country? If affirmative answer, indicate countries.	☐	☐
b. had close contact with, or shared time with a person who later was diagnosed with Covid-19 disease?	☐	☐
c. have experienced any of the following symptoms: chills, shivers, fever, headache, dry cough, throat pain, difficulty or insufficiency when breathing, extreme tiredness, muscular pains, loss of smell or taste, and/or any other disorder of the respiratory or pulmonary systems?	☐	☐
d. have had, or have been recommended by a licensed physician, medical professional, or a public health officer to be tested for the new coronavirus, SARS-CoV-2, or COVID-19 disease?	☐	☐
e. have been diagnosed and ordered solitary confinement at home? or have been hospitalized for any health problem associated to Covid-19 disease?	☐	☐

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OFFER DETAILS TO AFFIRMATIVE ANSWERS (If you need more space, refer to Section VIII of this application)

Proposed Insured's Name	Question Number	Physician's Name, Diagnosis, Treatment, Surgery, and Medicines taken regularly	Date (dd/mm/yyyy)	Current Health Status

VIII - ADDITIONAL INFORMATION AND COMMENTS

IX – SUPPORTING DOCUMENTS

☐ Copy of Identification(s)

☐ Other(s):

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X – DECLARATION AND AGREEMENT

DECLARATION. I, the Proposed Principal Insured or Legal Guardian, with my signature below hereby **DECLARE** and **CERTIFY** that I have read all of the questions in this Declaration and all answers provided by me, or by a Consultant or Representative designated by me are correct, complete, exempt of any misrepresentation and omission of relevant information to the risk. I **UNDERSTAND** these answers will be the basis utilized by the Company and/or its reinsurers to accept or decline this application, and if approved, the coverage requested will not be in effect until the Company issues a policy contract and collects the payment of premium. I **UNDERSTAND** a copy of this Declaration will become part of the insurance policy.

AGREEMENT. I, the Proposed Principal Insured or Legal Guardian, with my signature below, I hereby **AGREE** and **CONFIRM** that the Consultant or Representative designated by me has explained all benefits of the insurance coverage requested and I have received the Insurance Consumer Pre-Notices required by this application. I **AGREE** that specific details about the General Conditions, Insured Obligations, Limitations and Exclusions are contained in the policy contract. Also, I **AGREE** that:

1. The benefits provided by this insurance are subject to the payment of a Deductible and Coinsurance, the end of Waiting Periods, and payment of benefits according to the Usual, Customary and Reasonable costs for the same or similar service in the same geographic area, subject to the policy provisions, conditions, limitations and exclusions.
2. No information will be considered as offered to the Company, unless it is presented in writing. Information provided to, or the knowledge of the designated Consultant or Representative shall not be considered of the Company's knowledge, unless indicated in writing in this Declaration.
3. No designated Consultant or Representative has the authority to make changes, modify or compromise the rights of the Company under the policy.
4. All Premium Payment must be made payable to the Company. We are not responsible for payments made in cash or payable to a third party or entity.
5. The sale of the insurance herein requested is not authorized in the U.S.A. and its territories.
6. Any change in domicile and/or the country of residence declared in this application must be reported to the Company.
7. Any preexisting condition, disorder, lesion, accident or incapacity not declared in this Declaration and approved by the Company will not be covered. Any condition, disorder, lesion, accident or incapacity occurring prior to or on the date this Declaration is signed is considered a preexisting condition.
8. Any person who knowingly and with the intention to harm, defraud or mislead the Company presents a claim for benefits of an insurance policy containing false, incomplete or deceiving information, or willingly provides false information in the Declaration could be declared guilty of insurance fraud. In case it is found that the Declaration contains incorrect, incomplete, misleading information or omission of relevant information to the risk, the Company will decline benefits, rescind the policy as of the effective date, and will return premiums paid, less the policy fee and payment of benefits previously made by the Company.
9. All proposed insureds included in this Declaration, voluntarily **AGREE** to perform and disclose the results of any medical exam or test requested by the Company.

☐ I, the undersigned **ACCEPT** the terms and conditions of this Declaration and Agreement.

☐ I, the undersigned **CONSENT** to the Electronic Delivery of the Policy digital documents to my email included in this Declaration.

Name of the Proposed Principal Insured or Legal Guardian	Signature of the Proposed Principal Insured or Legal Guardian	Date (dd/mm/yyyy)

☐ I, the designated Consultant/Representative with my signature below, **DECLARE** that to the best of my knowledge all declarations provided on this Declaration are complete, correct, exempt of any misstatement or omission of relevant information to the risk. I also, **DECLARE** that as designated Consultant/Representative, I have completed this Declaration with full CONSENT of my client, the Proposed Principal Insured or Legal Guardian signing this Declaration.

Name of the Consultant/Representative	Signature of the Consultant/Representative	Code	Date (dd/mm/yyyy)

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XI - AUTHORIZATION

AUTHORISATION TO RELEASE INFORMATION

I, the Proposed Principal Insured or Legal Guardian, with my signature below and on behalf of all proposed insureds included in this Declaration, AUTHORISE and EXONERATE any physician, medical practitioner, medical professional, hospital, medical centre, clinic, insurer, MIB, LLC. (Medical Information Bureau) or any other person, organization or institution, governmental or not, to release any information about myself and all other proposed insureds included in this application to Redbridge Insurance Company, Ltd. its Reinsurers and Administrators, Regent International with the objective of assessing this application and any claims that are related to my insurance policy. Also, I AUTHORISE Redbridge Insurance Company, Ltd, its Reinsurers or Administrators to provide a short report to MIB, LLC. about myself and all other proposed insureds included in this Declaration.

MIB, LLC. is a non-profit organization which serves as a databank for exchange of information among the affiliated insurance companies, who have pledged to keep the confidentially of the information and uses the data exclusively to exercise their insurance functions such as underwriting, fraud detection and other contemplated purposes, to the extent permitted by the law.

If insurance is requested or a claim is presented to an affiliate company, such company may request to MIB, LLC. to release information they have about yourself. If a request from the solicitor is received, MIB, LLC. shall make the necessary arrangements to process the delivery of the information on file. If you understand that the information found in the MIB, LLC. files is incorrect, you may contact MIB, LLC. and request its correction.

The address of MIB, LLC. is 50 Braintree Hill Park, Suite 400, and Braintree, MA 02184-8734. The telephone number is (866) 692-6901. Also, you can visit their webpage www.mib.com.

☐ I, the undersigned, Authorised the Release of Information.

Name of the Proposed Principal Insured or Legal Guardian	Date of Birth (dd/mm/yyyy)	Signature of the Proposed Principal Insured or Legal Guardian	Signature Date (dd/mm/yyyy)

Delivering of these Notices to the Proposed Principal Insured or Legal Guardian is Required

REPORTING AGENCY NOTICES TO THE INSURANCE CONSUMER

PRE-NOTICE OF M.I.B. LLC.

Information regarding your insurability will be treated as confidential. Redbridge Insurance Company, Ltd. and its reinsurers may; however, make a brief report thereon to MIB, LLC. a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company; MIB upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901. If you question the accuracy of any information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Act. The address of MIB's information office is 50 Braintree Hill Park, Suite #400, Braintree, MA 02184-8734.

Redbridge Insurance Company, Ltd. or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information about MIB may be obtained on its website at www.mib.com

ANTI-FRAUD NOTICE

All answers declared in the insurance application by the Proposed Principal Insured or Legal Guardian, a Consultant or Representative will be the basis utilized by the Company to decline or accept the same, issue an insurance policy, make any modification and determine the rate or premium amount.

Any Declaration o claim under this policy that results in any respect or form fraudulent, or any other mechanism or means is used such as false information, misrepresentation or omission of relevant factors, or any intent of defraud or mislead is made to obtain an insurance policy or the payment of benefits that on the contrary would not have been approved or paid by the Company is considered insurance fraud. In case of an attempt of insurance fraud or if found that the Declaration contains incomplete, incorrect, misleading information, or omission of relevant information to the risk, the Company will decline benefits, rescind the policy rom the effective date and will return the amount of premiums paid less the policy fee and any payment of benefits previously made by the Company.

Fraud or attempted fraud is considered a crime convicted by law, subject to civil and criminal penalty.