GLOBAL BENEFITS GROUP
Insurance Without Borders™

Global 360 International Portfolio Application (Individual Medical Coverage)

NOTE: Submitting your application online will provide the fastest response. Please contact your agent for details.

1. To see more information about the products, please review the product sample policies and brochures.
2. You are responsible for completing this application and are solely responsible for its accuracy and completeness. All questions must be answered in full; all signatures and dates must be included where noted; otherwise the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. Type or print clearly using blue or black ink.
4. Email completed application to underwriting@gbg.com.

A. AGENT

Agent Name:	Agent Code:
Agent's Address:	

B-1. POLICY SELECTION

☐ GLOBAL SUPERIOR ☐ GLOBAL FREEDOM ☐ GLOBAL PREFERRED ☐ GLOBAL SECURITY ☐ GLOBAL INPATIENT

All plans offer Worldwide coverage except Global Inpatient (U.S. and Latin America only), choose Plan and Rider (if applicable):

Plan	Deductible Inside Country of Residence	Deductible Outside Country of Residence
☐ Plan 1 (Global Inpatient only)	0	1,000
☐ Plan 2	1,000	2,000
☐ Plan 3	2,000	3,000
☐ Plan 4	5,000	5,000
☐ Plan 5	10,000	10,000
☐ Plan 6	20,000	20,000

Add Complications of Pregnancy & Premature birth Rider? ☐ Yes ☐ No

Rider provides $500,000 Lifetime Maximum for Global Superior and Global Freedom with plans 4, 5 and 6.

Rider provides $500,000 Lifetime Maximum for Global Preferred and Global Security with plans 2, 3, 4, 5 and 6.

Note: Global Superior includes 100% UCR coverage up to policy limit on plans 2 and 3. Global Freedom includes $1,000,000 Lifetime Maximum for plans 2 and 3; Global Security and Global Preferred include $100,000 Lifetime Maximum for plans 2 and 3. Rider not available with Global Inpatient.

Add Transplant Procedures Rider? ☐ Yes ☐ No ($750,000 benefit; Available on Global Security and Global Inpatient.)

Billing Frequency: ☐ Annual ☐ Semi-Annual ☐ Quarterly

B-2. LIFE INSURANCE

Primary Insured's Life Insurance and Outstanding Claims Reimbursement Beneficiary

Primary Insured is beneficiary for Spouse/Dependents. Not included with Global Inpatient.

Last Name:	First Name (First, MI):
Address:	
Postal Code:	Country:
Relationship:	% of Benefit:

C. APPLICANT

Last Name:	First Name (First, MI):
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female
Weight: ☐ kgs ☐ lbs	Height: ☐ cm ☐ ft
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	
Country of Residence:	
Have you been covered by GBG before? ☐ Yes ☐ No	
Requested Policy Effective Date (MM/DD/YYYY; Subject to GBG Approval):	
Address:	
Postal Code:	Country:
Phone:	Email:

D. APPLICANT'S OCCUPATION	
Employer:	
Applicant's Title and Occupation (provide full description):	
Date of Hire (MM/DD/YYYY):	Hours worked per Week:
Annual Salary (Specify Currency):	
Address:	
Postal Code:	Country:

E. DEPENDENTS				
Relationship: SPOUSE	Last Name:	First Name (First, MI):		
Date of Birth (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
Weight:	☐ kgs ☐ lbs	Height:	☐ cm	☐ ft
Spouse's Occupation:		Spouse's Country of Residence:		
Relationship: CHILD	Last Name:	First Name (First, MI):		
Date of Birth (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
Weight:	☐ kgs ☐ lbs	Height:	☐ cm	☐ ft
Relationship: CHILD	Last Name:	First Name (First, MI):		
Date of Birth (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
Weight:	☐ kgs ☐ lbs	Height:	☐ cm	☐ ft
Relationship: CHILD	Last Name:	First Name (First, MI):		
Date of Birth (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
Weight:	☐ kgs ☐ lbs	Height:	☐ cm	☐ ft
Relationship:	Last Name:	First Name (First, MI):		
Date of Birth (MM/DD/YYYY):		Gender: ☐ Male ☐ Female		
Weight:	☐ kgs ☐ lbs	Height:	☐ cm	☐ ft

F. TRAVEL PATTERN: Anticipated travel pattern for the next 12 months.

Destination	Frequency	Duration	Duties

G-1. MEDICAL QUESTIONNAIRE: Complete for all members applying for coverage.		
1) Have you or any dependent(s) been treated, diagnosed, tested, hospitalized, or recommended for treatment for any of the following?		
1A) Seizures or seizure disorder; paralysis: multiple sclerosis; or any disorder of the central nervous system?	☐ Yes	☐ No
1B) Mental retardation; any mental, behavioral, emotional, or eating disorder; anxiety, depression, neurosis or psychosis; psychotherapy; psychological, or any form of counseling or therapy?	☐ Yes	☐ No
1C) High blood pressure; heart attack, stroke, chest pain or palpitations, murmur, varicose veins, blood clot, anemia, or any other blood heart, or circulatory disorder or condition? If yes, most recent blood pressure reading _____. Date recorded _____.	☐ Yes	☐ No
1D) Asthma; emphysema; bronchitis; sinusitis; pneumonia; allergies; apnea; or any breathing difficulty, lung or respiratory disease, disorder or condition?	☐ Yes	☐ No
1E) Colitis; chronic diarrhea, or intestinal problems; hernia; ulcer of the stomach or duodenum; hemorrhoids or rectal disorder; hepatitis or liver disorder; gallbladder, pancreas, esophagus, or any other digestive disorder or condition?	☐ Yes	☐ No
1F) Cancer, tumor, growth, cyst, enlarged lymph nodes; psoriasis, keratosis, lesions of the skin or mouth or any other skin disorder?	☐ Yes	☐ No
1G) Disease or disorder of the breast; kidney; kidney stones; bladder; prostate; abnormal PSA, or any other urinary disorder or infection?	☐ Yes	☐ No
1H) Disease or disorder of the genital or reproductive system; herpes, any sexually transmitted disease; endometriosis, or abnormal pap smear?	☐ Yes	☐ No
1I) Been treated for infertility; taken any medication, or advised to seek treatment, medication, diagnostic tests or surgery for infertility?	☐ Yes	☐ No
1J) Arthritis; rheumatism; gout; TMJ (temporomandibular joint syndrome); any injury to or disease or disorder of the spine, back, jaw, bones, muscles, or joints; joint replacement?	☐ Yes	☐ No
1K) Pituitary, adrenal, or thyroid disorder; lupus; diabetes? If yes to diabetes, state Type _____ and most recent blood sugar reading _____. Date recorded _____.	☐ Yes	☐ No
1L) Cataracts; glaucoma; or any eye disorder; hearing loss; or any ear, nose, or throat disorder?	☐ Yes	☐ No
1M) Alcoholism; alcohol, drug or substance abuse or dependency?	☐ Yes	☐ No
1N) Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), HIV Positive, or other immune disorders?	☐ Yes	☐ No
2) Have you been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed?	☐ Yes	☐ No
3) Are you currently pregnant? Expected Due Date: _____.	☐ Yes	☐ No
3A) If yes, is there a history of complications with previous pregnancies or are complications anticipated with this pregnancy?	☐ Yes	☐ No
3B) Is this pregnancy the result of infertility treatment?	☐ Yes	☐ No
4) Have you gained or lost more than 12 kilos or 25 pounds during the last 12 months?	☐ Yes	☐ No
5) Have you ever been declined, postponed, rated, or limited for Life, Health, or Accident Insurance?	☐ Yes	☐ No
6) Have you been hospitalized in the last 10 years for any reason?	☐ Yes	☐ No
7) Have you consulted or been advised to consult a medical practitioner, or do you suffer from any significant physical impairment, deformity sickness, or injury other than revealed in questions above?	☐ Yes	☐ No
8) Do you engage in any profession, sport, or hobby that could be considered hazardous?	☐ Yes	☐ No
9) Do you receive any disability pension or work accident pension?	☐ Yes	☐ No

G-2. Give details of each item answered "Yes" in Section G-1. If more space is needed, attach separate page(s) which must be signed and dated.

Patient's Name	Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates (From and To)	Ongoing or Date of Recovery	Name, Location and Phone Number of Physician/Facility

G-3. MEDICATION: List all medications that are currently prescribed for you or a family member.

Patient's Name	Medication Name	Dosage	Frequency	Reason for Use

H. FAMILY DOCTOR

Doctor/Facility/Provider Name:	
Address:	
Postal Code:	Country:
Phone:	Email:

I. RESIDENCE VERFICATION: Please complete Residence Verification Form for dependents if residency is different from yours.

By signing this Residence Verification Form, I, _____, certify that I am a resident of Latin America, defined as Mexico, Caribbean, Central and South America. I understand that residents of Brazil are not eligible to apply for this plan.

Any person whose permanent, full-time, residence is in Brazil or outside of Latin America is not eligible to apply for this plan. A resident is defined as the country where the insured resides the majority of any calendar or policy year; or where the insured has resided more than 180 days during any 12-month period while the policy is in effect. Should an insured change residency from original country to any other country in Latin America, United States, Canada, or other countries outside of Latin America, the person must immediately notify the insurer of his country change, and GBG will retain the right to modify benefits and premium.

I understand that I must notify Global Benefits Group, the insurer, immediately of any change in my residence status, of any move to another country. Failure to do so may result in the denial of claims as well as the recovery of any claims already paid. I also will notify Global Benefit Group and complete a Residence Verification Form for any dependents (spouse/partner/children) if their residency is different than mine. I will submit an address change via global360@gbg.com.

J. ACKNOWLEDGEMENTS AND AUTHORIZATIONS

1. I, the Undersigned, declare to the best of my knowledge and belief that the statements made in this Application are true and complete. It is my responsibility to inform GBG of any changes to these statements that occur prior to the completion of the Application being underwritten. Any intentional material misstatement or omission made on this Application will be considered a misrepresentation and may be the basis of a later rescission or termination of coverage, or denial of claims.
2. I consent to GBG seeking medical information from any doctor or facility who (that) has information concerning my medical history. This information will be used for the purpose of evaluating this Application.
3. I agree that there shall be no insurance in effect until GBG accepts/approves this application, in writing, secures premium, and establishes an effective date of coverage.
4. It is understood and agreed that no agent or broker of GBG has the authority to modify this application, waive the answer to any question, bind GBG in any way by seeking any promise or representation.
5. Acceptance of this coverage is not guaranteed and GBG reserves the right to accept or reject this application based upon the information submitted or developed during the course of underwriting. There is no coverage in force and GBG is not liable for claims incurred during the application process.
6. I understand and agree that if I have existing medical coverage, this coverage should remain in force until GBG approves this Application and notifies me of the effective date of coverage. I understand the no agent or broker of GBG has the right to accept this Application or bind coverage.

Applicant
Name:
Signature:
Date:

Please send completed application to our Global 360 team at **underwriting@gbg.com**.