CitizenSecure® Economy
Application and Rates

Important Instructions for All Applicants

1. Review your answers to each question on this Application for accuracy. Unanswered questions or incomplete information will delay processing.

2. All Applications must be signed and dated. Full details, including treatment dates, name, address and telephone number of attending physician, diagnosis, prognosis and present course of treatment must be provided for all “Yes” answers in Part 2.

3. All family members must apply for the same Deductible. You must select a Deductible in Part 1.

4. Annual premiums may be paid by check, money order or credit card authorization. **HCC Medical Insurance Services will not accept checks or money orders for monthly, quarterly, or semi-annual payment modes. These payment modes are only accepted with pre-authorization to debit your credit card on the due date(s) of your premium.**

5. **If monthly payments are selected, a valid email address must be provided in Part 5 of the Application.** If the credit card declines, HCC Medical Insurance Services will send notification of the credit card declination to this email address. The Applicant will have seven business days to submit new credit card information to avoid a lapse in coverage. To update and/or change credit card information, please visit Client Zone at https://zone.hccmis.com/clientzone.

6. If you are a US citizen, or if you are currently in the US, you must provide your anticipated date of departure from the US and your anticipated length of residence outside the US.

7. Upon approval, if you would like to have your Certificate sent to you by courier service, please add to your premium: $20 for delivery within the US (overnight service) or $30 to delivery outside of the US (express service).

8. Sign the Application in Part 6. If the spouse is applying, the spouse must also sign.

9. Be sure to answer all questions accurately and honestly. Any errors may cause the insurance to be voided.

Mail or fax completed Application to:

HCC Medical Insurance Services
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204
800.605.2282 / 317.262.2132
Fax: 317.262.2140
E-mail: insurance@hccmis.com

350.115.10.11 (9800)

HCC Medical Insurance Services

Application for Insurance – CitizenSecure® Economy

Part 1

Failure to provide complete information will delay processing.

Coverage	Deductibles			Dental Rider	Term Life	Sports Rider
Economy	☐ $250 ☐ $500	☐ $1,000 ☐ $2,500	☐ $5,000	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Requested Effective Date (must be within 30 days of signature)				Premium (from Part 5): $		

Note: Include only the family members applying for coverage. Attach additional sheets if necessary. Please print your name as you would like it to appear on your identification card.

Name (first name, middle initial, last name)		Date of Birth (mm/dd/yy)	Height	Weight	Citizenship
1. Applicant:	☐ Male ☐ Female	/ /			
2. Spouse:	☐ Male ☐ Female	/ /			
3. Child:	☐ Male ☐ Female	/ /			
4. Child:	☐ Male ☐ Female	/ /			
5. Child:	☐ Male ☐ Female	/ /			

Addresses must include: Street address, city, state, postal code, and country

Resident Address Outside of the United States (required if US citizen)	**Mail Forwarding Address for Written Correspondence** (if different from Resident Address)

Your Occupation:	Employer Name:
Date Hired:	Prior Employer (if within 2 years):

Home Telephone Number:	Work Telephone Number:
Fax Number:	E-mail Address:

If you or any family member are a US citizen or if you are currently in the US, the following information is required:	
Date of Departure from US:	Length of Residence outside of US:

Part 2

Please answer all questions for all members of the family included in this Application. Provide details of each "Yes" answer in Part 3.		
	Yes	**No**
1. Are you presently disabled, pregnant, unable to perform normal activities, Hospitalized, or scheduled for, or in need of Hospitalization or Surgery, or have you ever had, been recommended to have, or are you currently on a waiting list for any organ transplant?		
2. Have you ever had any indication, signs, symptoms, diagnosis, treatment, or tested positive for antibodies for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, or any other Immune System Disorder?		
3. Do you presently have or have you ever had Multiple Sclerosis, Parkinsons, Lou Gherigs disease (ALS), Down Syndrome or any form of mental retardation or chromosome disorder?		
4. Have you been diagnosed with or treated for any type of cancer or any form of diabetes during the last five (5) years?		
If any individual on the Application answers "Yes" to any of the above questions, they will not qualify for coverage under this plan. Thank you for your interest.		
Questions 5-20 below must be answered for each individual on the Application. For any questions answered "Yes," please identify the family member to whom the answer applies.	**Yes**	**No**
5. During the last 12 months, have you taken medication or received medical or mental health advice or treatment of any kind for any reason?		
6. Do you currently, or have you in the last 5 years, used tobacco in any form? If yes, please specify type and frequency in Part 3.		
7. In the last 5 years, have you consumed alcoholic beverages in the excess of 14 drinks per week? If yes, please specify type and how much per week in Part 3.		
Have you ever experienced symptoms of, manifestations of, suffered from, sought consultation, examination, testing or been treated for, or been prescribed medication, or have taken any type of over-the-counter medication, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from or relating to any of the following:	**Yes**	**No**
8. Heart, cardiac, cardiovascular and/or circulatory systems (including but not limited to: angina, chest pain, elevated blood pressure, hypertension, heart attack, congestive heart failure, arteriosclerosis, atherosclerosis, rheumatic fever, heart murmur, Mitral Valve Prolapse, tachycardia, atrial fibrillation, arrhythmia, swelling of feet/ankles, phlebitis, thrombosis or varicose veins)?		
9. Blood, blood vessels, veins, arteries or other blood anomalies (including but not limited to: hemophilia, leukemia, anemia, hepatitis or elevated cholesterol)?		
10. Cancer, tumor, cyst, polyp, lump, cell disorder, any condition or disease of the skin, or growth of any kind (including but not limited to: acne, any type of neoplasm, eczema or psoriasis)?		
11. Eyes, ears, nose, mouth, gums, throat, tongue or jaw (including but not limited to: Cataracts, Glaucoma, Hearing loss, Sinusitis, Deviated Nasal Septum, Chronic Sinus Disorders, Gum disease, Dysphasia or TMJ)?		
12. Pancreas, Gall Bladder, Liver, Thyroid, Obesity or any endocrine condition (including but not limited to: Pancreatitis, Gall Stones, Hyper/Hypo Thyroidism, Cushing's Syndrome or Hepatitis)?		
13. Kidney, Bladder, or Urinary System condition (including but not limited to: Kidney Stones, Renal Failure, Urinary Incontinence, or Chronic Kidney, Bladder or Urinary Tract infections)?		
14. Respiratory system (including but not limited to: asthma, allergies, allergic rhinitis, tuberculosis, lung disorder, emphysema, chronic cough or pneumonia)?		
15. Muscular or skeletal system (including but not limited to: scoliosis, disk disease, vertebrae or any back condition, rheumatism, fibromyalgia, any form of arthritis, gout, tendonitis, carpal tunnel syndrome, osteoporosis or any disorder of the tendons, cartilage, bone or joint)?		
16. Male or Female Reproductive system (including but not limited to: complicated pregnancy, menopause, ovarian cysts, uterine leiyoma, fibroids, breast cysts or nodules, infertility, prostatitis or elevated PSA level, testicular disorder or any sexually transmitted disease)?		
17. Digestive or Gastrointestinal System (including but not limited to: gastrointestinal or esophageal reflux, heartburn, gastritis, irritable bowel syndrome, ulcers, polyps or anal or rectal disorders)?		
18. Neurological disorders (including but not limited to: multiple sclerosis, muscular dystrophy, Lou Gehrigs disease, Parkinson's, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke or transient cerebral ischemic attacks)?		
19. Mental Health Disorder (including but not limited to: depression, psychosis, behavioral disorders, any form of Attention Deficit Disorder, chemical, alcohol or drug abuse or dependency, anxiety, chronic fatigue or any eating disorder)?		
20. Any other disease, medical problem, illness, injury, or condition of any kind?		

Part 3

For any question answered "Yes" in Part 2, please state the name of the family member and corresponding question number from Part 2. Provide complete details of the medical condition including: treatment dates, name, address and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Attach additional sheets if necessary. Additional information may be requested.	
#6 – Tobacco use (type and frequency of use)	#7 – Alcohol use (type and frequency of consumption)

Individual's Name and Question Number from Part 2	Condition / Diagnosis	Dates of Treatment / Prognosis / Degree of Recovery	Type(s) of Treatment and Present Course of Treatment	Physician and / or Facility Name, Address and Phone Number

Family History – Must be completed for all Applicants

Do you have a family history (mother, father, brother, and/or sister) of diabetes, cancer, heart disease, stroke, high blood pressure, and/or high cholesterol? Yes No If Yes, please complete the following (attach additional sheets if necessary):

Applicant name	Relationship	Condition	Age at onset	Current age, if living	Age at death, if deceased

Part 4

For each family member applying for Term Life insurance, please complete the following (**Term Life is not available for those in the United States**):	Coverage Elected
Applicant: Beneficiary:	☐ Option 1 ☐ Option 2
Spouse: Beneficiary:	☐ Option 1 ☐ Option 2
Child: Beneficiary:	☐ Option 1
Provide full address for each Beneficiary listed above (attach additional sheets if necessary):	

I understand Term Life and AD&D insurance will not become effective until the date of my departure from the US.

____________ (Applicant initial here) ____________ (Spouse initial here) ____________ (Initial here for Dependent Children)

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Part 5

PREMIUM CALCULATION

Applications without premium will not be processed. We will not accept checks or money orders for monthly, quarterly or semi-annual payment modes. For monthly, quarterly or semi-annual payment modes we will only accept a pre-authorized credit card. Checks, money orders or credit cards may be used for annual payment mode. Please make all checks and money orders payable to: HCC Medical Insurance Services.

Use the rate tables found on page 7 to enter premium amounts for the Medical portion (column 1) and any options elected (columns 2 through 4) below. Add the amounts in columns 1 through 4 for each individual and note the totals in column 5.

	(1) Medical	(2) Optional Dental Rider	(3) Optional Term Life	(4) Optional Sports Rider	(5) TOTAL
Applicant:	$ ______	$ ______	$ ______	$ ______	$ ______
Spouse:	$ ______	$ ______	$ ______	$ ______	$ ______
1st Child:	$ ______	$ ______	$ ______	$ ______	$ ______
2nd Child:	$ ______	$ ______	$ ______	$ ______	$ ______
3rd Child:	$ ______	$ ______	$ ______	$ ______	$ ______

Add all totals listed in column 5 and note the total here. $ ______ (Subtotal A)

Total First Payment Due

$ ______ (Subtotal A) X ______ *Modal Factor = $ ______

***Modal factors:** ☐ **Annual 1.00** ☐ **Semi-annual .55** ☐ **Quarterly .28** ☐ **Monthly .20**

Optional express mailing fee ($20 in US, $30 outside the US): $ ______

Total first payment due: $ ______

Remaining Payments (For semi-annual, quarterly, or monthly payment modes only)

$ ______ (Subtotal A) X ______ *Modal Factor = $ ______

***Modal factors:** ☐ **Semi-annual .55** ☐ **Quarterly .28** ☐ **Monthly .10**

Premium due for each additional installment : $ ______

Monthly payments are available only if valid e-mail address is provided:______________________
All correspondence regarding monthly payments will be made via e-mail to this address. For the monthly payment mode, there will be 10 additional monthly payments after the initial payment. If you elect monthly payments, the 11 payments will be drawn during the first 11 months of coverage.

Florida Surplus Lines – All applicants: Please indicate whether either of the following statements applies to you.

I am a Florida Resident who will be living and working abroad during my Certificate Period. I may return home for short periods of time.	☐ Yes ☐ No
I am a non-Florida resident who is coming to Florida for vacation or other non-work purposes.	☐ Yes ☐ No

Part 6

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to Members by Lloyd's. I have personally completed this Application. I represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I understand HCC Medical Insurance Services relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I understand that any misrepresentation or omission contained herein will void my insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by HCC Medical Insurance Services. I understand that if this Application is not accepted, the sole obligation of HCC Medical Insurance Services is to return to me any premium I have paid. I understand that this insurance contains a Pre-existing Condition exclusion, a Pre-certification penalty, and other restrictions, exclusions and limitations. I understand that I may obtain a copy of the Master Policy upon request to HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand that the insurance agent/broker, if any, assisting me with this Application is a representative of the Applicant. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis or physical or mental condition of any family member listed on this Application to release said information to HCC Medical Insurance Services.

Signature of Applicant, Guardian, or Power of Attorney	Signature of Spouse
Date of Signature	Date of Signature

Method of Payment

☐ Check or Money Order* (annual payments only) ☐ American Express ☐ Discover ☐ MasterCard ☐ VISA

All payments must be made in US Dollars. If paying by credit card, I authorize HCC Medical Insurance Services to debit my VISA/MasterCard/American Express/Discover account for the total amount due. If I have selected monthly, quarterly, or semi-annual payment modes, I hereby request and authorize HCC Medical Insurance Services to debit my credit card account for the proper installment amounts on their respective due dates. This authorization will remain in effect for up to 12 months or longer if the Certificate is renewed, or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

* Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please mail your Check or Money Order along with this Application to: Bank of America Lockbox Services ▪ c/o Lockbox # 15748 ▪ 540 W. Madison, 4th floor ▪ Chicago, IL 60661

Credit Card Number:	Expiration Date (mm/yy):
Name as it appears on card:	Billing Address:
Daytime Phone Number:	Signature:

Part 7

Producer Number:	Producer Name:	
Company Name:	Street Address:	
City:	State:	Postal Code:
Country:	Telephone:	Fax:
Email Address:	Signature:	

THIS MEDICAL AND DENTAL INSURANCE IS UNDERWRITTEN BY SYNDICATE 4141 AT LLOYD'S, LONDON. THIS LIFE INSURANCE IS UNDERWRITTEN BY SYNDICATE 308, ALSO AT LLOYD'S. THE INSURANCE IS AVAILABLE TO MEMBERS OF THE ATLAS/INTERNATIONAL CITIZEN GROUP INSURANCE TRUST, HAMILTON, BERMUDA. LLOYD'S IS AN APPROVED, NON-ADMITTED INSURER IN ALL STATES OF THE UNITED STATES, EXCEPT KENTUCKY AND ILLINOIS WHERE THEY ARE ADMITTED. CLAIMS UNDER THIS INSURANCE MAY NOT BE MADE AGAINST ANY STATE GUARANTY FUND.

New Business Annual Rates for Standard Risks

All amounts shown are in US Dollars

Rate Table – Medical Coverage – Economy

	$250 Deductible		**$500 Deductible**		**$1,000 Deductible**		**$2,500 Deductible**		**$5,000 Deductible**	
Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
14 days to 9*	$724	$724	$573	$573	$433	$433	$359	$359	$277	$277
10 to 18*	$1,014	$1,014	$815	$815	$630	$630	$547	$547	$444	$444
19-24	$1,000	$1,318	$806	$1,175	$627	$879	$553	$778	$454	$629
25-29	$1,036	$1,540	$846	$1,363	$657	$979	$577	$860	$475	$749
30-34	$1,143	$1,725	$941	$1,515	$733	$1,126	$649	$996	$531	$840
35-39	$1,242	$1,910	$1,035	$1,627	$800	$1,251	$709	$1,097	$580	$937
40-44	$1,603	$2,093	$1,327	$1,752	$1,028	$1,360	$913	$1,208	$744	$960
45-49	$1,803	$2,177	$1,611	$1,841	$1,248	$1,432	$1,107	$1,267	$904	$978
50-54	$3,237	$3,492	$3,119	$3,365	$2,889	$3,115	$2,449	$2,632	$1,964	$2,095
55-59	$4,337	$4,259	$4,197	$4,118	$3,916	$3,836	$3,377	$3,289	$2,764	$2,667
60-64	$5,330	$4,900	$5,176	$4,754	$4,860	$4,454	$4,255	$3,875	$3,548	$3,201
65-69	$12,324	$10,748	$11,876	$10,298	$10,980	$9,397	$8,536	$7,104	$7,405	$6,253
70	$14,532	$12,564	$14,076	$12,122	$13,167	$11,213	$10,381	$8,427	$9,005	$7,285
71	$15,214	$13,166	$14,758	$12,712	$13,849	$11,802	$10,933	$8,886	$9,485	$7,680
72	$15,795	$13,665	$15,347	$13,215	$14,446	$12,314	$11,408	$9,280	$9,896	$8,021
73	$16,395	$14,167	$15,950	$13,722	$15,057	$12,832	$11,902	$9,674	$10,325	$8,362
74	$17,193	$14,846	$16,747	$14,401	$15,856	$13,509	$12,536	$10,187	$10,875	$8,807

*Medical coverage for the first 2 children ages 14 days to 9 is free only when both parents are insured under the Economy plan. The Dependent Child rate is only available when at least one parent (guardian) is insured under the same Economy plan. Dependent children alone must pay the '19-24 Male' rate.

Rate Table – Optional Term Life and AD&D Insurance

Age	Option 1	Option 2
19-29	$130	$ 230
30-39	$210	$ 370
40-44	$310	$ 545
45-49	$450	$ 790
50-54	$570	$1,000
55-59	$770	$1,350
60-64	$585	$1,025
65-69	$315	Not Available
Dependent Child	$ 85	Not Available

Rate Table – Optional Dental Rider

US Citizen	$348
All Others	$492

Rate Table – Optional Sports Rider

Age 14 days – 59 years	$250

Rates effective through 01/31/2012 Rates include Surplus Lines Taxes and Fees when applicable