

**CitizenSecure<sup>®</sup>**  
**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 Coverage Area and Deductible. You must select a Coverage Area and 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. The 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 e-mail 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 e-mail 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](mailto:insurance@hccmis.com)

# Application for Insurance – CitizenSecure®

## Part 1 Failure to provide complete information will delay processing.

Coverage Area	Deductibles	Dental Rider	Term Life	Sports Rider
Including US/Canada	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excluding US/Canada	<input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
2. Spouse:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
3. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
4. Child:	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /			
5. Child:	<input type="checkbox"/> Male <input type="checkbox"/> 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. Have you ever had an application for health or life insurance voided, declined, cancelled, rescinded or modified (including medical exclusion riders)?		
2. In the last 24 months, have you used tobacco in any form? If yes, please specify type and frequency in Part 3.		
3. In the last 12 months, have you experienced a weight change of 15 pounds or more?		
4. In the last 5 years, have you had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any alcohol or drug related arrest?		
5. In the last 5 years, have you consumed alcoholic beverages in excess of 14 drinks per week? If yes, please specify type and how much per week in Part 3.		
6. Are you pregnant or do you have an adoption pending?		
7. Do you (not including dependent children) read, write, speak and understand English? If no, what is your primary language?		
8. In the last 12 months, have you taken medication or received medical advice or treatment of any kind?		
<b>Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease or disorder of:</b>	<b>Yes</b>	<b>No</b>
9. Gallbladder, pancreas, or liver?		
10. Skin?		
11. Joints or spine?		
12. Kidney?		
13. Eyes, ears, or nose?		
14. Mouth, throat, or jaw?		
<b>Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of:</b>	<b>Yes</b>	<b>No</b>
15. High blood pressure?		
16. Chest pain?		
17. Headaches?		
18. Paralysis?		
19. Arthritis?		
20. Convulsions or epilepsy?		
21. Elevated cholesterol?		
22. Sexually transmitted disease?		
23. Cancer?		
24. Diabetes or sugar in the blood or urine?		
25. Stroke?		
26. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?		
27. Tumor, cyst, polyp, lump or growth of any kind?		
<b>In the last 10 years, have you:</b>	<b>Yes</b>	<b>No</b>
28. Had a complicated pregnancy or delivery?		
29. Tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional or received medical advice or treatment for a mental health condition?		
<b>In the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease, disorder, or abnormality of the:</b>	<b>Yes</b>	<b>No</b>
32. Heart or circulatory system?		
33. Nervous system?		
34. Digestive system?		
35. Muscular or skeletal system?		
36. Respiratory system?		
37. Male or female reproductive system?		
38. Urinary system?		
39. Thyroid, breast, or other glands?		
40. In the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse or abnormal test results?		

### 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 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.

#2 – Tobacco use (type and frequency of use)	#5 – Alcohol use (type and frequency of consumption)
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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:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Spouse: Beneficiary:	<input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2
Child: Beneficiary:	<input type="checkbox"/> 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)

## 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:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
1 <sup>st</sup> Child:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2 <sup>nd</sup> Child:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3 <sup>rd</sup> 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: <input type="checkbox"/> Annual 1.00 <input type="checkbox"/> Semi-annual .55 <input type="checkbox"/> Quarterly .28 <input type="checkbox"/> Monthly .20				
Optional express mailing fee: (\$20 in US, \$30 outside the US):				\$ _____
<b>Total first payment due:</b>				\$ _____

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

\$ _____ (Subtotal A)	X	_____	=	\$ _____
		*Modal Factor		
*Modal factors: <input type="checkbox"/> Semi-annual .55 <input type="checkbox"/> Quarterly .28 <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
I am a non-Florida resident who is coming to Florida for vacation or other non-work purposes.	<input type="checkbox"/> Yes <input type="checkbox"/> 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, 4<sup>th</sup> 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:
E-mail 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 Including the US and Canada**

Age	\$250 Deductible		\$500 Deductible		\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
14 days to 9*	\$846	\$846	\$669	\$669	\$505	\$505	\$419	\$419	\$323	\$323
10 to 18*	\$1,184	\$1,184	\$952	\$952	\$735	\$735	\$639	\$639	\$518	\$518
19-24	\$1,169	\$1,539	\$942	\$1,371	\$732	\$1,026	\$646	\$909	\$530	\$734
25-29	\$1,209	\$1,799	\$989	\$1,592	\$766	\$1,143	\$674	\$1,005	\$554	\$875
30-34	\$1,336	\$2,014	\$1,099	\$1,769	\$855	\$1,315	\$758	\$1,163	\$620	\$981
35-39	\$1,451	\$2,232	\$1,208	\$1,900	\$934	\$1,460	\$828	\$1,281	\$676	\$1,094
40-44	\$1,872	\$2,445	\$1,549	\$2,047	\$1,201	\$1,588	\$1,066	\$1,411	\$869	\$1,121
45-49	\$2,106	\$2,543	\$1,881	\$2,150	\$1,458	\$1,672	\$1,293	\$1,479	\$1,055	\$1,142
50-54	\$3,780	\$4,078	\$3,644	\$3,930	\$3,375	\$3,638	\$2,860	\$3,074	\$2,293	\$2,448
55-59	\$5,066	\$4,975	\$4,902	\$4,810	\$4,574	\$4,480	\$3,945	\$3,842	\$3,229	\$3,115
60-64	\$6,227	\$5,724	\$6,046	\$5,552	\$5,676	\$5,202	\$4,971	\$4,527	\$4,144	\$3,739
65-69	\$14,397	\$12,555	\$13,872	\$12,030	\$12,826	\$10,978	\$9,973	\$8,299	\$8,651	\$7,304
70	\$16,976	\$14,677	\$16,443	\$14,162	\$15,381	\$13,099	\$12,128	\$9,845	\$10,520	\$8,510
71	\$17,771	\$15,379	\$17,240	\$14,851	\$16,178	\$13,787	\$12,773	\$10,381	\$11,080	\$8,973
72	\$18,451	\$15,963	\$17,926	\$15,437	\$16,875	\$14,386	\$13,328	\$10,842	\$11,562	\$9,370
73	\$19,152	\$16,550	\$18,632	\$16,030	\$17,589	\$14,990	\$13,904	\$11,301	\$12,061	\$9,768
74	\$20,085	\$17,342	\$19,563	\$16,822	\$18,522	\$15,781	\$14,645	\$11,901	\$12,704	\$10,288

**Rate Table – Medical Coverage Excluding the US and Canada**

Age	\$250 Deductible		\$500 Deductible		\$1,000 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
14 days to 9*	\$661	\$661	\$522	\$522	\$394	\$394	\$327	\$327	\$254	\$254
10 to 18*	\$924	\$924	\$742	\$742	\$573	\$573	\$500	\$500	\$405	\$405
19-24	\$911	\$1,201	\$734	\$1,070	\$571	\$801	\$504	\$710	\$414	\$574
25-29	\$944	\$1,404	\$771	\$1,242	\$598	\$891	\$526	\$784	\$433	\$684
30-34	\$1,043	\$1,572	\$858	\$1,380	\$667	\$1,025	\$592	\$908	\$485	\$766
35-39	\$1,132	\$1,742	\$943	\$1,483	\$728	\$1,140	\$646	\$1,000	\$528	\$853
40-44	\$1,517	\$1,980	\$1,256	\$1,658	\$973	\$1,287	\$864	\$1,142	\$703	\$909
45-49	\$1,707	\$2,060	\$1,524	\$1,742	\$1,181	\$1,354	\$1,047	\$1,198	\$855	\$926
50-54	\$3,062	\$3,304	\$2,953	\$3,184	\$2,735	\$2,947	\$2,318	\$2,490	\$1,857	\$1,982
55-59	\$4,155	\$4,080	\$4,020	\$3,943	\$3,751	\$3,675	\$3,234	\$3,150	\$2,650	\$2,556
60-64	\$5,107	\$4,694	\$4,959	\$4,552	\$4,655	\$4,267	\$4,077	\$3,711	\$3,399	\$3,068
65-69	\$11,805	\$10,296	\$11,376	\$9,864	\$10,517	\$9,002	\$8,178	\$6,805	\$7,093	\$5,989
70	\$14,090	\$12,182	\$13,648	\$11,754	\$12,767	\$10,872	\$10,066	\$8,171	\$8,731	\$7,063
71	\$14,751	\$12,765	\$14,309	\$12,326	\$13,427	\$11,444	\$10,602	\$8,616	\$9,195	\$7,447
72	\$15,315	\$13,250	\$14,878	\$12,813	\$14,007	\$11,941	\$11,063	\$8,999	\$9,595	\$7,778
73	\$15,896	\$13,738	\$15,464	\$13,306	\$14,600	\$12,442	\$11,541	\$9,379	\$10,011	\$8,107
74	\$16,671	\$14,395	\$16,237	\$13,962	\$15,373	\$13,098	\$12,156	\$9,879	\$10,544	\$8,538

\* Medical coverage for the first 2 children ages 14 days to 9 years is free only when both parents are insured under the same plan. The Dependent Child rate is only available when at least one parent (guardian) is insured under the same 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	\$1000
55-59	\$770	\$1350
60-64	\$585	\$1025
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
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Rates effective through 01/31/2012

Rates include Surplus Lines taxes and fees when applicable