



**IC+ TERM LIFE INSURANCE – FOR THE INTERNATIONAL MARKET  
APPLICATION FOR INSURANCE**

**Proposed Insured**

Name			
Resident Address outside the United States (include City, State, Country, and Postal Code)			
Mailing Address (include City, State, Country, and Postal Code)			
Telephone No.	Fax No.	E-Mail:	
Date of Birth:	Citizenship:	Gender:	

**Proposed Policy owner (if different from above)**

Name			
Address (include City, State, Country, and Postal Code)			
Telephone No.	Fax No.	E-Mail:	

**Reason for insurance (check applicable box)**

Personal/Family Protection	
Inheritance tax	
Private Residential Loan	
Keyman	
Commercial Loan	

**Occupation**

1. Nature of Business or Occupation:	_____	
2. Does your job require a license (e.g. driving)?	Yes	No
3. Rank and duties if a member of the Armed Forces:	_____	
4. Do your duties involve you in any way (other than clerical) with:		
a. The licensed trade or entertainment industry?	Yes	No
b. Working at heights, offshore, aviation (other than scheduled flights), diving or the fishing or mining industries, work requiring special safety precautions or any other activity that may be regarded as hazardous?	Yes	No
If yes, give full details:		

## Policy Details

Term: (10 year maximum)	Principal Sum \$	Desired Effective Date: / /			
Total Principal Sum under existing life insurance policies (please circle appropriate box):					
\$0 to \$100,000	\$100,001 to \$250,000	\$250,001 to \$500,000	\$500,001 to \$750,000	Over \$750,001	
Are you currently purchasing or intending to purchase any other life insurance or have you done so within the last 12 months?				Yes	No
If yes, please provide details of companies, dates and amounts of insurance:					
_____					
_____					

## Personal Details

Height:	Weight:		
<b>Provide details to all "Yes" answers.</b>		<b>Yes</b>	<b>No</b>
1. Have you ever had an application for health or life insurance voided, declined, canceled, rescinded or modified (including medical exclusion riders)?			
2. In the last 12 months, have you used tobacco in any form?			
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?			
6. Are you pregnant?			
7. Do you 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>			
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>			
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?			
28. Had a complicated pregnancy or delivery?			

29. Tested positive for antibodies to the HIV virus?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional?		

<b>Within the last 10 years, have you had any indications, signs, symptoms, diagnosis or treatment of any disease, disorder, or abnormality of the:</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. Within the last 10 years, have you had any signs, indication, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse finding or had any adverse or abnormal test results?		

For any question answered "Yes", provide details of the condition including: treatment dates, name, address, and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Additional information may be requested.			
Condition / Diagnosis	Dates of Treatment / Prognosis	Type(s) of Treatment and Present Course of Treatment	Physician and/or Facility Name, Address, and Phone Number

<b>Doctor who currently holds your medical records:</b>			
Name			
Address			
Telephone No.	Fax No.	E-Mail	
If you have changed doctors within the last 3 months, please provide the following information regarding your previous doctor:			
Name			
Address			
Telephone No.	Fax No.	E-Mail	

**Beneficiary (if other than Policy owner)**

Name:	Relationship to Applicant:		
Address			
Telephone No.	Fax No.	E-Mail:	

**Contingent Beneficiary:**

Name:	Relationship to Applicant:		
Address			
Telephone No.	Fax No.	E-Mail:	

## Declaration/Application

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 (HCCMIS) relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meet 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 HCCMIS. I understand that if this Application is not accepted, the sole obligation of HCCMIS is to return any premium I have paid to me. I understand that this insurance contains restrictions, exclusions and limitations. I understand that I may obtain a copy of the Master Policy upon request to HCCMIS. 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 HCCMIS. 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 HCCMIS.

Signature of Applicant: \_\_\_\_\_ Date:        /        /

Country Location at time of signature:

Signature of Policy owner (if different): \_\_\_\_\_ Date:        /        /

## Premium Calculation

**IMPORTANT PAYMENT INFORMATION:** Applications without premium will not be processed. HCCMIS will not accept checks or money orders for quarterly or semi-annual payment modes. For quarterly or semi-annual payment modes, HCCMIS 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 payable to: HCC Medical Insurance Services.

$$\begin{array}{c} \$ \underline{\hspace{2cm}} \\ \text{Annual Premium} \end{array} \times \begin{array}{c} \underline{\hspace{2cm}} \\ \text{*Modal Factor} \end{array} = \$ \underline{\hspace{2cm}} \\ \text{Premium Due}$$

\*Modal Factor: Annual = 1.00, Semi-Annual = .55, Quarterly = .28)

## Method of Payment

Check or Money Order (Annual Pay Mode Only)     MasterCard     VISA     American Express     Discover

The check or money order should be payable to HCC Medical Insurance Services. All payments must be made in U.S. 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 elected semi-annual or quarterly payment modes, I hereby request and authorize HCC Medical Insurance Services to debit my credit card account for the proper installment amounts on the due dates of the installments. 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.

Credit Card Number: \_\_\_\_\_ Expiration Date:        /

Name as it appears on card: \_\_\_\_\_ Daytime Phone #:

Billing Address:

Signature:

Producer Number:		Producer Name:	
Company Name:		Street Address:	
City:	State:	Postal Code:	
Country:	Telephone:	Fax:	
E-Mail:	Signature:	Date:	