GLOBAL NAVIGATOR HEALTH PLAN

Renewable worldwide major medical coverage for Maritime Crew

Fully complies with state insurance department standards

Crossborder Services LLC

HTH Worldwide

HEALTHY SOLUTIONS FOR THE GLOBAL TRAVELER

HTH Worldwide **is an innovator and leader in helping world travelers and global citizens stay safe and gain easy access to quality health-care all around the world.**

global innovator

What is Global Navigator?

Global Navigator?

What is Global Navigator?

Worldwide health insurance and services for maritime crews and employers

The Global Navigator health plan is designed to meet a crew member's need for comprehensive worldwide benefits—inside and outside the U.S.—without the time limits, eligibility conditions and benefit exclusions common among traditional plans. Global Navigator is the premier maritime health plan because it combines these benefits with concierge-level medical assistance and easy access to an elite community of carefully selected hospitals outside the U.S. and a network of over 700,000 doctors and hospitals inside the U.S. Global Navigator gives crews peace of mind, knowing they always have the freedom to access top medical care and benefits no matter where their voyages take them.

Affordable monthly premium with no loading!

Global Navigator Features **HTH** Worldwide's Global Health and Safety Services — Because crew members need more than insurance.

What good is insurance if you can't find a doctor you can trust?

HTH Worldwide provides all the tools a Global Navigator needs to manage health and safety risks, including finding the right doctor and clearly communicating your medical condition.

Easy Access to an Elite International Provider Community

HTH's expanding International Provider Community is approaching over 5,000 carefully selected medical providers in almost every country of the world. Because of HTH's rigorous selection criteria, less than 2% of providers outside the U.S. qualify to participate. Covering more than 100 specialties and subspecialties, the Provider Community database is searchable online to review detailed profiles of each provider.

Participating doctors, dentists and behavioral health professionals are English-speaking and individually contracted to schedule outpatient visits via HTH's online request service and to accept payment directly from HTH.

Global Navigator members are always free to choose any medical provider outside the U.S. without incurring a financial penalty.

The Freedom to Access Care in the U.S.

Global Navigator members also gain access to a contracted nationwide network of over 700,000 preferred providers, including more than 4,000 hospitals. The plan also covers care delivered by non-contracted providers.

Emergency Evacuation and Centers of Excellence

HTH coordinates emergency services with a worldwide network of contracted Physician Advisors as well as air ambulance operators selected for their safety records. Members in need of life-saving medical intervention are treated in Centers of Excellence in the U.S. and around the world whenever possible.

Around-the-Clock Assistance Call Center

HTH maintains a 24/7, toll-free call center to assist Global Navigator members with everything from routine requests to medical emergencies. HTH staff has years of experience with international medical assistance and has close working relationships with its International Provider Community.

Unsurpassed Member Services

Appointment Scheduling and Direct Pay—Paperless, Cashless, Convenient

Using the web, the telephone or a web-enabled cell phone, members can request appointments with doctors and hospitals who participate in HTH's International Community. When making appointments, HTH arranges to pay the doctor or hospital directly.

Personalized Recruitment—Meeting Your Needs and Expectations

If members need a physician in a location not currently covered by HTH's International Community, HTH makes every effort to recruit an appropriate, qualified doctor.

Well Prepared and Informed Choice—To Get the Care You Need

Members can create a Well Prepared personal web page to store search results for physicians, drug translations and more. If members experience unanticipated medical problems, they can request local, regional or global treatment alternatives through the Informed Choice service.

mPassport℠—Vital Information in the Palm of Your Hand

Members can locate emergency services, search for a doctor, hospital or pharmacy, translate drug brand names and key medical terms and receive up-to-the-minute health and safety alerts from their web-enabled cell phones via HTH's mPassport service.

Why Choose HTH Worldwide's Global Navigator Plan

A Recognized Leader

HTH Worldwide is a recognized leader in international health insurance and medical assistance services, serving hundreds of thousands of world travelers annually.

Highest Standards of Service

Global Navigator is administered by HTH Worldwide Insurance Services to meet the highest expectations. HTH has set new standards for international assistance services and for applying stringent criteria when contracting with doctors and hospitals outside the U.S.

Strength of a U.S. Regulated Insurer

- Global Navigator is underwritten by A-rated insurance companies licensed by state departments of insurance as admitted carriers.
- Global Navigator protects your rights by meeting the standards of state regulators and features benefits more generous than non-admitted "surplus coverage."

Group Quotes Available

- Boat owners and managers can cover crews of any size with a group plan.
- Group plan designs can be customized.
- Plans are HIPAA compliant and offer COBRA coverage.

Top 10 Advantages over Competing Plans

1. No limit on time spent in or out of the U.S.*
2. Deductible is waived for office visits to participating providers outside the U.S. and preferred providers inside the U.S.
3. Alcohol related injuries are covered.
4. Administered using HIPAA guidelines — the pre-existing condition exclusion can be reduced or waived with proof of prior creditable insurance.
5. No waiting periods associated with any preventive services.
6. Sailboat racing covered to policy maximum.
7. Covers injuries or illnesses that are a result of a terrorist act.
8. No precertification required except for transplants.
9. No excluded transplants.
10. Affordable monthly premium with no loading.

*Please Note: Eligible Members returning to their home country are covered for a maximum of 12 months.

How the Plan Works

Global Navigator offers comprehensive benefits and a range of deductible options that allow members to select the right amount of insurance coverage for their budget and lifestyle. For detailed benefit schedule and rates, please see inserts. To calculate your total out-of-pocket expense, add the deductible and coinsurance maximum.

For families, the deductible and coinsurance maximum is a multiple of 2.5.

After 12 months of continuous coverage, Global Navigator members may renew their coverage or apply for a new plan that covers maternity costs in the same way as all other medical conditions.

To be eligible for the maternity benefit, a member must not be pregnant at the time of upgrade.

Global Navigator Options

Plan	Deductible			Coinsurance Maximum
	Outside U.S.	U.S. in Network	U.S. out of Network	
250	$125	$250	$500	$2,000
1000	$500	$1,000	$2,000	$4,000
2500	$1,250	$2,500	$5,000	$8,000
5000	$2,500	$5,000	$10,000	$10,000

Amounts paid to satisfy a deductible are credited to all other deductibles.

For detailed benefit schedule and rates, please see inserts.

Applications are available online or may be initiated by telephone or email. See back cover for details.

A personal check, money order or credit card number must accompany the application and must be sufficient to pay for one month of standard premium. HTH will hold the form of payment until an underwriting decision is made. If your application is accepted, the payment will be applied to your account. Quotes obtained online or by telephone are advisory only. Actual premium is determined by the medical underwriting process.

HTH Worldwide will review your medical history as provided on the application and may request an Attending Physician's Statement. HTH publishes standard premium rates for non-smokers. Smokers and other applicants with certain medical histories may be offered a policy at a higher rate. Not all applicants will be accepted. Your effective date of insurance will be on the 1st or 15th day of the month following underwriting approval.

Member Welcome Kit

When your application is accepted, HTH Worldwide will mail you and any family members covered under the plan a Welcome Kit with identification cards, a certificate of insurance and instructions on how to register online to use the Global Health and Safety Resources. Procedures for filing a claim or requesting direct payment of participating providers will also be included.

Renewals

Global Navigator is annually renewable and coverage is continuous when renewed. You must continue to meet the plan's eligibility requirements. There are no medical questions at renewal and premium rates do not change based on your individual claims history. Your renewal rate will be the same as all persons renewing in your rating class.

After 12 months of continuous coverage, Global Navigator members may apply for a new plan that covers maternity costs in the same way as all other medical conditions. Members must submit a simple Health Statement to supplement their original application.

How Coverage Ends

Your coverage ends on the earlier of:

1. The last day of the month after the date the Insured Person is no longer eligible;
2. The end of the last period for which premium has been paid;
3. The date the Policy terminates;
4. The date the Lifetime Maximum Benefit of the Plan has been exhausted;
5. The date of fraud or misrepresentation of a material fact by the Insured Person, except as indicated in the Time Limit on Certain Defenses provision.

Extension of Benefits

If an Insured Person is Totally Disabled on the date of termination of the Policy, coverage will be extended until the earlier of:

1. The date payment of the maximum benefit occurs;
2. The date the Insured person ceases to be Totally Disabled; or
3. The end of 90 days following the date of termination.

Pre-existing conditions

The Global Navigator plan does not cover services for treatment of a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during 365 days immediately preceding the member's eligibility date.

Creditable coverage

The 365-day pre-existing conditions period can be reduced or eliminated if you have been covered by a creditable group or individual health insurance plan.

Conforms to state requirements

If any provision of a Global Navigator plan is in conflict with the statutes of the state in which the member resides, it is amended to conform to the minimum requirements of those statutes.

For benefits, rates, exclusions, eligibility and other important information, please see inserts.

GLOBAL NAVIGATOR BENEFIT SCHEDULE

Global Navigator has three tiers of coinsurance: 100% outside the U.S., 80% in network in the U.S., 60% out of network inside the U.S. All Global Navigator plans have a **$5,000,000 lifetime maximum** and a $250,000 maximum benefit for emergency medical evacuation.

The Out-of-Pocket Maximum is calculated by adding the deductible and coinsurance maximum together. Please refer to chart on page 3 of brochure.

Benefits	Outside the U.S.	In Network, U.S.	Out-of-Network, U.S.
Primary and Preventative Care – Deductible is Waived			
Primary Care Office Visits - as many as 4 visits per Calendar Year	All except a $10 copay per visit	All except a $30 copay per visit	60% to Coinsurance Maximum then 100%
Preventative Care for Babies/Children: (Birth to Age 18) for Office Visits/Examination and Immunizations, Lab work & X-rays	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Preventative Care For Adults: (Age 19 and Older) for Routine Pap Smears, Annual Mammogram and PSA For Men	100%	80% to Coinsurance Maximum then 100%	80% to Coinsurance Maximum then 100%
Annual Physical Examination Health Screening	100% Maximum Covered Expense of $250 and limited to one per Calendar Year.	80% to Coinsurance Maximum then 100% Maximum Covered Expense of $250 and limited to one per Calendar Year.	60% to Coinsurance Maximum then 100% Maximum Covered Expense of $250 and limited to one per Calendar Year.
Outpatient Services – Insurer pays after the Deductible is Met			
Outpatient Medical Care	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Inpatient Hospital Services – Insurer pays after the Deductible is Met			
Surgery, X-rays, In-hospital doctor visits, Organ/Tissue Transplant	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
In-Patient Medical Emergency	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Professional Services-Surgery, Anesthesia, Radiation Therapy, In-Hospital Doctor Visits, Diagnostic X-ray and Lab Work.	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Other Services – Insurer pays after the Deductible is Met, unless noted			
Ambulatory Surgical Center	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Physical/Occupational Therapy/Medicine	Deductible is waived. Covered Expenses up to $50 per visit, and as many as 6 visits per Calendar Year		
Ambulance Service	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Durable Medical Equipment	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse			
a. Mental Health, Inpatient: Up to 20 days per Year	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
b. Mental Health – Outpatient: 10 visits per Year	50%	50%	50%
c. Alcoholism or Drug Abuse – Inpatient Up to 10 days per Year	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
d. Alcoholism or Drug Abuse – Outpatient: Up to 10 visits per Year	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Outpatient Prescription Drugs	100% of actual charge up to an annual maximum of $1,000. Maximum 90 - day supply		
Dental Care Required Due to an Injury	100% of Covered Expenses up to $500 per Calendar Year maximum		
Accidental Death and Dismemberment	Deductible is waived. Maximum Benefit: Principal Sum up to $10,000		
Repatriation of Remains	Deductible is waived. Maximum Benefit up to $25,000		
Medical Evacuation	Deductible is waived. Maximum Lifetime Benefit for all Evacuations up to $250,000		

Global Navigator Health Plan Prices

Effective March 1, 2010

Monthly Premium Rate Table

	Global Navigator Plan			
	250	1000	2500	5000
Male				
Under 30	$123	$110	$95	$83
30-34	$138	$122	$105	$91
35-39	$163	$145	$124	$109
40-44	$202	$180	$154	$135
45-49	$259	$230	$197	$173
50-54	$314	$279	$239	$210
55-59	$405	$361	$309	$272
60-64	$527	$470	$402	$353
65-69	$935	$834	$713	$626
70-74	$1,344	$1,198	$1,025	$901
Female				
Under 30	$161	$143	$122	$108
30-34	$172	$153	$131	$114
35-39	$198	$176	$151	$133
40-44	$255	$228	$195	$172
45-49	$305	$272	$232	$205
50-54	$351	$314	$268	$235
55-59	$388	$345	$296	$260
60-64	$450	$402	$343	$301
65-69	$799	$712	$608	$535
70-74	$1,146	$1,021	$873	$768
Child (when insured with their parent)				
One Child under Age 1	$201	$179	$153	$134
One Child 1-17	$144	$129	$110	$97
2 Children	$241	$215	$184	$162
3 Children	$321	$286	$245	$216

Prices are subject to change

HTH Worldwide

1. Who is eligible to buy a Global Navigator plan?

An Eligible Member must be under Age 75 and their country of assignment is other than the Eligible Member's home country and must be a professional crew member. Eligible Members returning to their home country are covered for a maximum of 12 months.

2. How do I qualify for maternity benefits?

After 12 months of continuous coverage, Global Navigator members may apply for a new plan that covers maternity costs in the same way as all other medical conditions. Members must submit a simple Health Statement to supplement their original application indicating their pregnancy status.

3. Will my policy automatically renew? At what rate?

Global Navigator is renewable up to age 74. Policies are renewed at prevailing rates based on age. Your personal health history will not determine the renewal rate. Existing members must confirm their renewal rates in writing in order to be renewed. They will be notified approximately 30 days prior to renewal.

4. When does my coverage end?

We may terminate your policy if:

You no longer meet the eligibility requirements; or you fail to pay your premium; or you exhaust the Lifetime Maximum Benefit of the plan; or we discover that you committed fraud or misrepresented a material fact to us, except as indicated in the time limit of certain defenses provision; or we terminate the plan in your geographic service area.

5. Who is the insurer?

Strength in ratings, top industry support

Our international health insurance plans are backed by a U.S. Insurer, no matter how much time you spend in or out of the U.S. U.S. admitted health insurance is among the most regulated in the world and offers optimum customer protection.

- HM Life Insurance Company of Pittsburgh, PA rated A- (Excellent) by A.M. Best
- UNICARE Life & Health, a WellPoint company rated A- (Excellent) by A.M. Best

FAQs continued ▶

6. Will my pre-existing condition be covered under a Global Navigator plan?

If you were previously covered by an annually renewable health plan that issues you a Certificate of Creditable Coverage, HTH Worldwide will credit you for this prior coverage. The number of months of coverage shown on the Certificate will reduce or eliminate the 12-month pre-existing condition waiting period. If you have 12 or more months of creditable coverage, your waiting period will be eliminated. If you have less than 12 months creditable coverage, your waiting period will be reduced by the number of months you had creditable coverage. For example, if you have 2 months of creditable coverage, your waiting period will be reduced from 12 months to 10 months.

Please Note: Surplus lines insurance does not constitute creditable coverage.

7. Am I guaranteed to be issued a Global Navigator policy if I apply?

No, Global Navigator is not a guaranteed issue plan. Each application is medically underwritten. Your application may be 1) accepted, 2) accepted with a rate increase due to your health status, or 3) denied.

8. Is the quote I receive binding?

No. The quote you receive may not apply if 1) you misstated a material fact on your application, or 2) we increase the rate due to your health status.

9. What is the Global Citizens Association?

GCA is a not-for-profit association serving those who travel the world for business, study and leisure. GCA promotes health and safety around the world through online knowledge tools and email news alerts. GCA members also benefit from the Association's group purchasing programs for travel, insurance, entertainment and telecommunication services. GCA benefits are available through its Rewards Worldwide program at www.rewardsworldwide.*com*.

10. What about accessing participating providers?

HTH's Global Health and Safety services help members identify, access and pay for quality healthcare all over the world, including a contracted community of elite providers in 180 countries. Members can access these carefully selected providers and arrange for the bills to be sent directly to HTH Worldwide. Please note that in the U.S. a member can simply show his/her ID card at time of service and participating providers will only bill the member for any applicable deductible or copayment. Members have access to a U.S. PPO Network through Aetna. Whether overseas or in the U.S., members can choose to use any doctor or hospital. Members are never restricted to a network. Please see the benefit schedules to see how coinsurance may apply.

Excluded Services

The Plan does not provide benefits for:

1. Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Plan.
2. Services **not specifically listed** in this Plan as Covered Services.
3. Services or supplies that are **not Medically Necessary** as defined by the Insurer.
4. Services or supplies that the Insurer considers to be **Experimental or Investigative.**
5. Services received **before the Effective Date** of coverage or during an inpatient stay that began before that Effective Date of Coverage.
6. Services received **after coverage ends** unless an extension of benefits applies as specifically stated under Extension of Benefits in the 'Who is Eligible for Coverage' section of this Plan.
7. Services for which the Insured Person has **no legal obligation to pay** or for which no charge would be made if he/she did not have a health policy or insurance coverage.
8. Services for any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
9. Conditions caused by or contributed by: (a) an **act of war;** (b) The inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) An Insured Person participating in the **military service** of any country; (d) An Insured Person participating in an **insurrection, rebellion, or riot**; (e) Services received for any condition caused by an Insured Person's commission of, or attempt to commit a **felony or to which a contributing cause was the Insured Person being engaged in an illegal occupation**; (f) An Insured Person, age 19 or older, being under the influence of illegal narcotics or non-prescribed controlled substances unless administered on the advice of a Physician.
10. Any services provided by a local, state or federal **government agency** except when payment under this Plan is expressly required by federal or state law.
11. Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption, or the Insured Person's employer.
12. Inpatient or outpatient services of a **private duty nurse.**
13. Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change, physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
14. Inpatient room and board charges in connection with a Hospital stay primarily for **diagnostic tests**, which could have been performed safely on an outpatient basis.
15. Treatment of **Mental, Emotional of Functional Nervous Disorders** (including nicotine use) or psychological testing except as specifically stated in this Plan. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
16. **Drug, alcohol, or other substance addiction or abuse,** except as specifically stated in this Plan.
17. **Dental services,** dentures, bridges, crowns, caps or other dental prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically stated under <u>Dental Care for Accidental Injury</u> in the Benefits section of this Plan.
18. Dental and orthodontic services for Temporomandibular Joint Dysfunction.
19. **Orthodontic Services,** braces and other orthodontic appliances.
20. **Dental Implants:** Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
21. **Hearing aids.**
22. Routine **hearing tests** except as provided under Preventive and Primary Care.
23. **Optometric services,** eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Plan.
24. An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
25. Outpatient **speech therapy**.
26. Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Plan. This includes, but is not limited to, items dispensed by a Physician.
27. Any intentionally **self-inflicted** Injury or Illness. This exclusion does not apply to the Medical Evacuation Benefit, to the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

28. **Cosmetic surgery** or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a newborn child, or to Medically Necessary reconstructive surgery performed to restore symmetry incident to a mastectomy.
29. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.
30. Treatment of **sexual dysfunction** or inadequacy.
31. All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization.
32. All **contraceptive** services and supplies, including but not limited to, all consultations, examinations, evaluations, medications, medical, laboratory, devices, or surgical procedures unless stated otherwise.
33. **Cryopreservation** of sperm or eggs.
34. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
35. Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care, which involves weight reduction as a main method of treatment.
36. **Routine physical exams** or tests that do not directly treat an actual Illness, Injury or condition, including those required by employment or government authority except as specifically stated under the Professional and other Services , Preventive and Primary Care and Annual Physical Examination/Health Screening sections of this Plan.
37. Charges by a provider for **telephone consultations.**
38. Items, which are furnished primarily for the Eligible Participant's **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc.).
39. **Educational services** except as specifically provided or **arranged** by the Insurer.
40. **Nutritional counseling** or food supplements.
41. **Durable medical equipment** not specifically listed as Covered Services in the Covered Services or Infusion Therapy sections of this Plan. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings.
42. Any services received on or within 12 months after the Effective Date of coverage if they are related to a **Pre-existing Condition** as defined in the Definitions section.
43. **Growth Hormone Treatment.**
44. Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet.
45. **Charges for which the Insurer is unable to determine the Insurer's liability** because the Eligible Participant or an Insured Person failed, within 60 days, or as soon as reasonably possible to (a) authorize the Insurer to receive all the medical records and information the Insurer requested or, (b) provide the Insurer with information the Insurer requested regarding the circumstances of the claim or other insurance coverage.
46. Charges for the services of a **standby Physician.**
47. Charges for **animal to human organ transplants.**
48. Loss arising from:
    a. participating in any **professional sport**, contest or competition;
    b. **skin/scuba diving**.

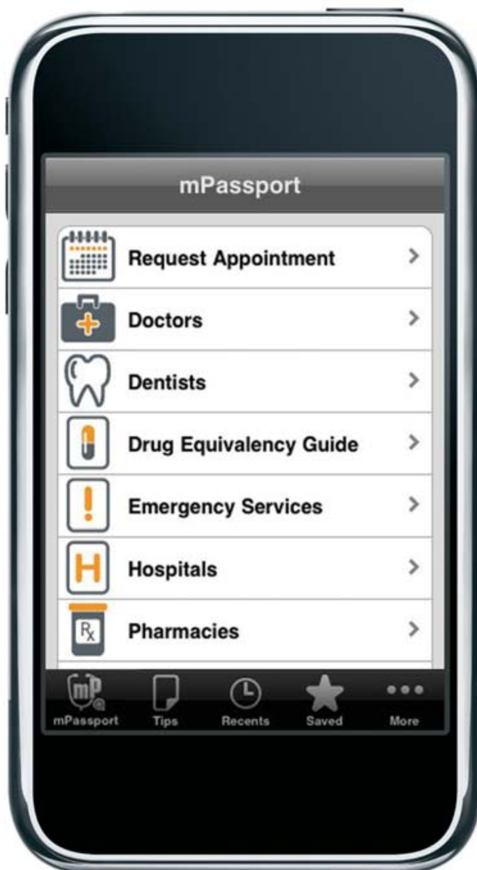
Pre-existing Conditions
Benefits are not available for any services received: (1) on or within 12 months after the Eligibility Date of an Insured Person who is not a Late Enrollee if those services are related to a **Pre-existing Condition** as defined in the Definitions section. This exclusion does not apply to a Newborn that is enrolled within 31 days of birth or a newly adopted child that is enrolled within 31 days from either the date of placement of the child in the home, or the date of the final decree of adoption.
Exception: The Insurer will credit time an Insured Person was covered by Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of Coverage under this Plan, excluding the Waiting Period.

This limitation does not apply to the Medical Evacuation Benefit, the Repatriation of Remains Benefit and to the Bedside Visit Benefit.

On the go, on the web, on your phone!

The mobile way to trusted medical care, anywhere in the world

HTH Worldwide Presents...



Use your mobile phone to:

- Choose from over 5,400 selected, English speaking doctors in 182 countries.
- Find selected hospitals and clinics in over 1,400 destinations.
- Search notable pharmacies in over 500 international destinations.
- Translate medication brand names and key medical terms and phrases.
- Receive personalized health and safety alerts via text message or e-mail.

HTH Worldwide

Global Navigator Health Plan
Application Instructions

HTH Worldwide

Thank you for applying with HTH Worldwide.

- **Global Navigator Health Plan is specially designed for members of the Global Citizens Association.**
- **Coverage is not guaranteed until approved in writing by HTH Worldwide. Do not cancel your current insurance coverage until you have been notified of approval by HTH Worldwide that your Global Navigator coverage is effective.**

Instructions

Do not complete this application until you have read the current product brochure or website.

Please follow these instructions to allow us to better process your application.

- **For your own protection, you, the applicant, must complete this application. You are solely responsible for its accuracy and completeness.**
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**
- This application must be received by HTH Worldwide within thirty (30) days from the signature date.
- Even if this application is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**
- Please return this application and your check to your agent OR mail to the address listed.

Payment Information

Please see page 7.

Most common causes for delay in underwriting

- Missing, inaccurate or incomplete information such as:
  - Weight AND Height
  - Spouse's social security, or passport number
  - Dependent's social security, or passport number
  - Date of birth
  - Date of last pelvic examination
  - Results of last pelvic examination
  - Physician's address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city and state.
- ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Additional documentation or information is required.

Mailing Address

- **Applicant:** Please return this application to the address below or to your agent.

  HTH Worldwide
  Attn: Underwriting Department
  100 Matsonford Road
  Suite 100
  Radnor, PA 19087
  USA

Faxing an Application

- To expedite underwriting please fax to 610.293.3529.
- HTH Worldwide must be in receipt of original document to issue policy. After faxing the application please mail original application to your agent or to the mailing address listed above.

Passport No.
Or, Applicant's Social Security No.
Agent I.D. No. 41782

HTH Worldwide

Global Navigator Health Plan Enrollment Application

Application must be completed by the applicant in blue or black ink.

Reason for Application (Check one)

❑ New Enrollment(s)

❑ Add dependent(s) to I.D. No: ______

To change existing plan, please enter I.D. No: ______

1. Applicant Information (Please Print)

Primary Applicant's Last Name	First Name	M.I.

Address

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City		Postal Code	Country

Mailing Address (In Care Of)

In Care Of:			
Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	State	Postal Code	Country

Home Phone No. ( )	Daytime Phone No. ( )	Marital Status ❑ Single ❑ Married
Business Phone No. ( )	Fax No. ( )	Passport No.
Email Address		Maiden Name of Applicant/Spouse (If applicable)

2. Time and Location Status

What is the name of your current vessel and country of registration? ______

How much time in the next 24 months will you be outside of your home country? ______

What locations? ______

______

How did you hear about HTH Worldwide? ______

3. Choice of Plan

Global Navigator (Includes Benefits in the U.S.)

❑ 250 ❑ 1000 ❑ 2500 ❑ 5000

4. Applicants for Coverage

Check one: ❑ Insure all eligible applicants ❑ Insure no one unless all are accepted for coverage

Please list all applicants applying for coverage. (List children youngest to oldest)
If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name First Name M.I.	MUST BE ACCURATE Height	Weight	Date of Birth	Social Security/Passport No.
❑ Male ❑ Female	Yourself				
❑ Husband ❑ Wife	Spouse				
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					

Passport No.

Or, Applicant's Social Security No.

4. Applicants for Coverage continued

Applies to couples or families:
If extenuating circumstances prevent all family members from applying, please attach detail and a determination will be made by the company whether or not the application can be considered.

If you are married or have children, are all family members applying for coverage? ❑ Yes ❑ No ❑ N/A

If No, Why? ____________________

Are you a U.S. Citizen? ❑ Yes ❑ No

Please list your occupation and duties.

Please provide the name of your employer.

Please provide your employers address.

5. Other Coverage - Please answer **all** of the following questions.

A. Do you currently have or has anyone to be insured had coverage in the last 18 months? . . . . ❑ Yes ❑ No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

Name of insured(s)	Insurance carrier(s)	Effective date	End date

Do you agree to discontinue your current coverage if this application is accepted? . . . . ❑ Yes ❑ No

If No, please explain:

B. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? . . . . ❑ Yes ❑ No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

C. Are any persons applying for coverage on this application eligible for U.S. Medicare or Medicaid benefits? . . . . . . ❑ Yes ❑ No

If Yes, please list all eligible person(s). Note: Any applicant eligible for U.S. Medicare Part A or B is not eligible for Global Navigator.

Eligible person(s)

D. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? . . . . ❑ Yes ❑ No

If Yes, please provide the following information.

Name of applicant	Effective date	End date

Passport No.

Or, Applicant's Social Security No.

6. Health History – Include information on all family members you wish to enroll.

6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.
Has any person listed on this application received medical advice, diagnosis or treatment, or had treatment or consultation recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years?**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis or any other neurological or central nervous system disorder(s) ❑ Yes ❑ No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy or any similar symptoms ❑ Yes ❑ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ❑ Yes ❑ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever or any other circulatory condition ❑ Yes ❑ No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition ❑ Yes ❑ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring or use of a sleep monitoring device ❑ Yes ❑ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ (Temporomandibular Joint Dysfunction) ❑ Yes ❑ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids or any other digestive disorder or condition ❑ Yes ❑ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type:________) ❑ Yes ❑ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ❑ Yes ❑ No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio or any other musculoskeletal disorder ❑ Yes ❑ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation or prosthesis ❑ Yes ❑ No
13. Diabetes, thyroid, pituitary, adrenal or any other endocrine disorders ❑ Yes ❑ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ❑ Yes ❑ No
15. Is any applicant a candidate for or a recipient of an organ or bone marrow transplant? ❑ Yes ❑ No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery or any other skin conditions ❑ Yes ❑ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ❑ Yes ❑ No
18. Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction or penile implant ❑ Yes ❑ No
19. a) Breast disorder/cyst, lump, fibroid tumors, silicone injections or implants ❑ Yes ❑ No
    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ❑ Yes ❑ No
    c) Date and result of last pelvic exam/Pap smear for each female over 16:
    Name:_______________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal
    Name:_______________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal
    Name:_______________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal
    ❑ N/A I have not had a pelvic exam/Pap smear.
    d) Is the applicant, spouse or any dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? ❑ Yes ❑ No
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ❑ Yes ❑ No
21. Diseases or problems of the ears or hearing, implant or hearing aid ❑ Yes ❑ No
22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. ❑ Yes ❑ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:___________________________________ ❑ Yes ❑ No
24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ❑ Yes ❑ No

Has any person listed on this application ever:

25. Had cancer, tumor/growth, leukemia or cyst? ❑ Yes ❑ No
26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery or treatment? ❑ Yes ❑ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? ❑ Yes ❑ No
28. Been diagnosed as having or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? ❑ Yes ❑ No

IMPORTANT: Applicant's medical conditions, which occur after the signature date and before the approval date that come to HTH Worldwide's attention, may be considered in the final underwriting decision.

Passport No.
Or, Applicant's Social Security No.

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ❑ Normal ❑ Abnormal	❑ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ❑ Normal ❑ Abnormal	❑ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal	☐ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

6C. Prescription Medications –

List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

6D. Other Health Questions

Question		1.		2.	
1. Has any applicant ever smoked or used any tobacco products such as: cigarettes, cigars, pipe, snuff or chewing tobacco?	❑ Yes ❑ No	1. Family member	Amount per day	2. Family member	Amount per day
		Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent?	❑ Yes ❑ No	1. Family member		2. Family member	
		Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs?	❑ Yes ❑ No	1. Family member		2. Family member	
		Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	❑ Yes ❑ No	1. Family member		2. Family member	
		Amount ________ per ❑ day ❑ week ❑ month		Amount ________ per ❑ day ❑ week ❑ month	
		Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years?	❑ Yes ❑ No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. ☐ **No. of sheets attached**

Passport No.

Or, Applicant's Social Security No.

7. Conditions of Application

It is important that you carefully read and fully understand the following.

I, the undersigned, understand that, under the Global Navigator plan for which I am applying, I may be entitled to lesser benefits if I use a nonparticipating hospital, physician, or other provider, than if I use a participating hospital, physician or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 9, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 30-60 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance and will prevent you from being required to pay for two policies.

NOTE: If a child is born to the participant the child has to be registered within 31 days. All other children including adopted children must go through underwriting.

❑ I request that HTH Worldwide assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.

❑ If HTH Worldwide approves my application, please assign an effective date of the

- ❑ 1st of the month following approval.
- ❑ 15th of the month following approval.
- ❑ 1st of ____________ ❑ 15th of ________________.

This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE **DOES NOT GUARANTEE** UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ONLY HTH WORLDWIDECAN CHANGE THIS DATE, HOWEVER, HTH WORLDWIDE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN IS ISSUED.

Initial X__________

Initial Term

Please issue coverage for the initial term of:

❑ 6 months ❑ 7 months ❑ 8 months ❑ 9 months

❑ 10 months ❑ 11 months ❑ 12 months

(Minimum of six months required.)

Billing Date

Charged on the 1st or 15th of the month (depending on your policy effective date).

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium amount required with this application. If my application is denied, HTH Worldwide will return the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
2. If my application for Global Navigator coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by HTH Worldwide that my application is approved.
3. I understand that HTH Worldwide has the right to deny my application and if it does so, I will be notified in writing and the premium I submitted will be returned.
4. MINOR CHILDREN: I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. CONCERNING DEPENDENTS AGE 18 AND OVER: I represent that my dependents age 18 and over (1) have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 6A, 6B, 6C and 6D with them and (3) all information contained in this application regarding them is complete and accurate.
6. I understand and agree that if HTH Worldwide rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, and/or cashing of my premium check or charging this amount to my credit card by HTH Worldwide does not constitute approval of my application or create Global Navigator coverage.
7. If I am accepted, this application will become part of the agreement between the insurance carrier and myself.
8. HTH Worldwide may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, HTH Worldwide will determine payment, and I will be responsible for any difference.
9. The selling agent has no authority to promise me coverage or to modify underwriting policy or terms of any Global Navigator coverage.
10. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. HTH Worldwide may void all coverage from the original effective date of the agreement for such material intentional misstatements or omissions. HTH Worldwide may void all coverage from the original effective date of the agreement for such material intentional misstatements or omissions discovered prior to the end of the contestable period.

    If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.

    PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.

Association Membership

I understand that this product is being offered only to members of the Global Citizens Association. I agree to become a member of the Association at no obligation. As a member of the Association, I shall be entitled to a variety of benefits, which includes the ability to purchase this insurance product. For further information visit www.gcassociation.org.

Yes. I Agree X________________________________

Signature

FRAUD NOTICE Please read carefully

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may by subject to civil or criminal penalties, depending upon state law.

For your protection, California requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an insurance application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

In Kentucky, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Any application for insurance in writing by the applicant shall be altered solely by the applicant or by his written consent except that insertions may be made by the insurer for administrative purposes only in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Ohio, any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Oklahoma, **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

In Pennsylvania, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorization/Disclosure Statement

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide HTH Worldwide's authorized underwriters or Medical Directors, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders (other than psychotherapy notes), AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through thirty (30) months. A photocopy of this Authorization is as valid as the original. My authorized representative, or I am entitled to receive a copy of this form. I understand any request for psychotherapy notes will require separate authorization.

I understand and agree to all the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 10). I have read and understand this Application in its entirety. I certify that I have received an outline of coverage.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (required if applying for coverage)	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

Notice of Information Practices

If you apply for or are covered by an HTH Worldwide health care plan, HTH Worldwide may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, HTH Worldwide may provide information to a hospital in order to verify benefits. Upon your request, HTH Worldwide will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. HTH Worldwide can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

Passport No.
Or, Applicant's Social Security No.

ATTACH INITIAL PREMIUM CHECK HERE.
DO NOT TAPE.

8. Payment Method – Submit initial premium with application (required).

8A. Initial Deposit

1month premium $ _________
- ❑ I am attaching a check/money order for the above amount
- ❑ Please charge my credit card for the above amount

3 month premium $ ________
- ❑ I am attaching a check/money order for the above amount
- ❑ Please charge my credit card for the above amount

6 month premium $ _________
- ❑ I am attaching a check/money order for the above amount
- ❑ Please charge my credit card for the above amount

12 month premium $ _________
- ❑ I am attaching a check/money order for the above amount
- ❑ Please charge my credit card for the above amount

All checks should be made payable to HTH Worldwide Insurance Services and drawn from a U.S. bank account.

Credit Card information (only if applicable) ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover		Credit Card No.	Expiration Date
Cardholder's Name	Cardholder's ZIP Code	Authorized Signature (as it appears on the credit card) X	Today's Date

8B. Payment Type (First payment will be credited to approved applicants only.)

Monthly Deduction
- ❑ From Checking Account
- ❑ Charge to Credit Card

Quarterly Deduction
- ❑ From Checking Account
- ❑ Charge to Credit Card

Semi-Annual Deduction
- ❑ From Checking Account
- ❑ Charge to Credit Card

Annual Deduction
- ❑ Charge to Credit Card

Checking Account and credit card deductions are done on the first or the 15th of the month depending on the effective date of the policy.

8C. Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated or if paying initial premium by credit card, attach a voided check. If the account listed below is a joint account, both account holders' signatures are required. HTH Worldwide must be notified of any changes to your bank account no later than the 20th of the month preceding the change. Checking account deduction is available on U.S. bank accounts.

AUTHORIZATION: As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of HTH Worldwide provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will be the same as if it were a check drawn on you and signed personally by me. I authorize HTH Worldwide to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Global Navigator premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

Applicant Name	Applicant Social Security No.		Name on Checking Account			
Name of Bank or Financial Institution	Address		City		State	ZIP Code
Checking Account No.	Bank Routing No.		Federal Credit Union Routing No.			
Authorized Signature (as it appears in the financial institution's records)		Date	Authorized Signature (as it appears in the financial institution's records)	Date		

(Continued on reverse)

DO NOT WRITE BELOW

Insurance Underwritten by HM Life Insurance Company

Pittsburgh, PA under policy form series HM207-SI, HM207-TH or HM207-EH GC.

The coverage requested may not be available in all states

Passport No.
Or, Applicant's Social Security No.

9. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, ______________________________, personally read and completed this Individual Enrollment Application for the applicant named below because:

❑ Applicant does not read English
❑ Applicant does not speak English
❑ Applicant does not write English
❑ Other *(explain)*:______________________

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: ______________________________

I also translated and fully explained the "Conditions of Application (Section 7)."

By X______________________________ ______________________

Signature of Translator Today's Date (Required)

10. Conditional Receipt – To be completed by the agent and given to the applicant.

Received from______________________ $ __________ as a premium, payable to HTH Worldwide Insurance Services.

Subject to the following:

IN NO EVENT SHALL HTH WORLDWIDE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE PREMIUM SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY HTH WORLDWIDE.

Dated this __________ day of ______________ , 20 ______.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By ______________________________ ______________________

X Signature of Agent Agent I.D. Number

HTH Worldwide

How to Apply

Mail Crossborder Services LLC
Five Green Tree Center
Suite 104, Route 73
Marlton, NJ 08053

Visit www.americanvisitorinsurance.com
E-Mail info@americanvisitorinsurance.com

Call 877-340-7910