Global Citizen Health Plan
Application Instructions

HTH Worldwide

Thank you for applying with HTH Worldwide.

- **Global Citizen 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 Citizen 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is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.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, visa, or passport number
  - Dependent's social security, visa, 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, state and ZIP code.
- 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: Individual Underwriting Department
  100 Matsonford Road
  Suite 100
  Radnor, PA 19087

Expediting an Application

- To expedite underwriting please fax to 610.672.9635 or email underwriting@hthworldwide.com.

HTH Worldwide

Global Citizen Health Plan Individual Enrollment Application

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

Applicant's Social Security No.

Visa/ Passport No.

Agent I.D. No. 41782

1. Applicant Information (Please Print)

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

Reason for Application (Check one)

❑ New Enrollment(s)

❑ Add dependent(s) to I.D. No: _____

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

Address Outside the US

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

Address Inside the US

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City		State	ZIP Code

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. ( )	Spouse's Social Security/ Visa/ Passport No.
Email Address		Maiden Name of Applicant/Spouse (If applicable)

2. Time and Location Status

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 Citizen (Includes Benefits in the U.S.)

❑ Elite ❑ 500 ❑ 1000 ❑ 2000 ❑ 5000 ❑ 10000 ❑ 25000

Global Citizen EXP (Excludes Benefits in the U.S.)

❑ Elite ❑ 250 ❑ 500 ❑ 1000 ❑ 2500 ❑ 5000 ❑ 10000

Prescription Drug Rider ❑ Yes ❑ No

Dental and Vision Rider (Elite Plans only) ❑ Yes ❑ No

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	MUST BE ACCURATE Weight	Date of Birth	Social Security/ Visa/ Passport No.
❑ Male ❑ Female	Yourself				
❑ Husband ❑ Wife	Spouse				
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					

Applicant's Social Security No.

Visa/ Passport No.

4. Applicants for Coverage continued

Applies to couples or families:
All family members must apply for coverage to be eligible. 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	Are you a foreign national residing legally in the U.S.? ❑ 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 Medicare or Medicaid benefits? . . . . . ❑ Yes ❑ No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for Global Citizen but may be eligible for Global Citizen EXP.

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

Applicant's Social Security No.

Visa/ Passport 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

    e) Are you intending to become pregnant in the next 18 months? ❑ 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.

Applicant's Social Security No.
Visa/ Passport 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. 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? ❑ Yes ❑ No Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	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

Applicant's Social Security No.

Visa/ Passport 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 Citizen 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 WORLDWIDE CAN 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 ☐ 364 days
(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 Citizen 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 Citizen 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 Citizen 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.

    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.

Arkansas Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

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.

Louisiana Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

New Mexico ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

Oklahoma 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.

Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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.

Applicant's Social Security No.

Visa/ Passport 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

364 days 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.

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

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 Citizen 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 364 days, 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

Your insurance coverage is underwritten by an outstanding U.S. Admitted Company—BCS Insurance Company, rated A- (Excellent) by A.M. Best for financial strength. BCS Insurance Company, known for innovative product development and special risk underwriting, is based in Oakbrook Terrace, Illinois.

To find out more about BCS, visit http://www.bcsigroup.com/plan/about/introduction.html

Applicant's Social Security No.

Visa/ Passport 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