MWAII MORGANWHITE ADMINISTRATORS INTERNATIONAL, INC.

APPLICATION FOR DISABILITY INSURANCE

	APPLICANT'S NAME			RELATIONSHIP	SEX	DATE OF BIRTH			AGE	HEIGHT	WEIGHT
	FIRST NAME	I.	LAST NAME			DAY	MTH	YEAR			
1											
2											
3											
4											
5											
6											
7											
8											

PAYMENT MODE	
ANNUAL O SEMI ANNUAL O CHEQUE O CREDIT CARD O	PLAN DEDUCTIBLE

	APPLICANT	MEDICAL COVERAGE	PREMIUM AMOUNT	LIFE INSURANCE AMOUNT	PREMIUM AMOUNT	AD&D AMOUNT	PREMIUM AMOUNT	TOTAL COVERAGE
1			$		$		$	$
2			$		$		$	$
3			$		$		$	$
4			$		$		$	$
5							TOTAL	$

Permanent Residence (Including City & State)	Mailing Address	Telephone Number
		Fax Number
	Email Address	

Employer or Other Postal Address	Occupation and Duties	Telephone Number
		Fax Number
	Email Address	

ANNUAL PREMIUM	$	MODAL FACTOR	X	PREMIUM DUE	$

1.	**Has any applicant proposed for coverage ever been advised to or received medical consultation, care, treatment or taken medication for:** ***(Please circle each condition)***	**YES**	**NO**	**Give full details on "yes" answers of each applicant including diagnosis, dates, duration, names and addresses of all attending physicians and medical facilities.**
a.	Heart or circulatory system (including but not limited to infarction, high blood pressure, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins or arteries) and/or any other symptom regarding the circulatory system or heart, which if referred to a doctor would result in a diagnosis.			
b.	Respiratory system (including but not limited to deviated septum, sinusitis, polyps or cyst, asthma, bronchitis, emphysema, bronchiectasis, tuberculosis) and/or any other symptom regarding the respiratory system, which if referred to a doctor would result in a diagnosis.			
c.	Gastrointestinal system (including but not limited to gastro esophageal reflux, hiatal hernia, gastritis, gastric or duodenal ulcer, duodenitis, diverticulosis, diverticulitis, polyps, colitis, gallbladder diseases) and/or any other symptom regarding the gastrointestinal system, which if referred to a doctor would result in a diagnosis.			
d.	Urinary system (including but not limited to kidney diseases, stones, infections, urinary tract disease, bladder disorders, prostate diseases) and/or any other symptom regarding the urinary system, which if referred to a doctor would result in a diagnosis.			
e.	Musculoskeletal system (including but not limited to back disorders, spinal cord disorders rheumatism, arthritis/arthrosis, gout, lumbago, osteoporosis, deformity, herniated disc) and/or any other symptom regarding the musculoskeletal system, which if referred to a doctor would result in a diagnosis.			
f.	Neoplastic disorders (Benign or malignant).			
g.	Endocrine system (including but not limited to Hypophysis gland diseases, Thyroid, Parathyroid, Diabetes, Ovaries and Adrenal gland disorders) and/or any other symptom regarding the endocrine system, which if referred to a doctor would result in a diagnosis.			
h.	Sexually transmitted diseases or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex).			
i.	Female reproductive system (including but not limited to disorders of menstrual cycle, ovaries, uterus including cervix, endometriosis, pelvic inflammatory diseases, fallopian tubes, vagina, miscarriages, cesarean section). Breast disorders (including but not limited to fibrocystic diseases, tumor) and/or any other symptom regarding the female reproductive system or breast, which if referred to a doctor would result in a diagnosis.			
j.	Male reproductive system (including but not limited to prostate, testes, penis) and/or any other symptom regarding the male reproductive system, which if referred to a doctor would result in a diagnosis.			
k.	Neurological system (including but not limited to convulsions, epilepsy, paralysis, Multiple Sclerosis, cerebral infarction, Alzheimer's disease, Dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.			
l.	Liver disorders (including but not limited to fatty liver, Cirrhosis, Hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.			
m.	Any skin disorders (including but not limited to acne, psoriasis, melanomas, carcinomas).			
n.	Hematologic and Lymphatic system (including but not limited to anemia, leukemia, multiple myeloma, Waldenstrom's Macroglobulinemia, Spleen's disorders and other blood and coagulation disorders) and/or any other symptom regarding the Hematologic and Lymphatic system, which if referred to a doctor would result in a diagnosis.			
o.	Collagen's diseases (including but not limited to Rheumatoid Arthritis, Systemic lupus Erythematosus, Scleroderma) and/or any other symptom regarding collagen diseases, which if referred to a doctor would result in a diagnosis.			
2.	**HAS ANY PERSON PROPOSED FOR COVERAGE**			
a.	Had health examinations or routine medical check-ups? Any abnormalities?			
b.	Been a patient in a hospital, clinic or sanatorium?			
3.	**HAS ANYONE PROPOSED FOR COVERAGE BEEN RECOMMENDED TO UNDERGO A SURGERY THAT IS STILL PENDING?**			

4.	IS ANYONE CURRENTLY TAKING ANY PRESCRIBED MEDICATION OR UNDER MEDICAL TREATMENT OR HAS BEEN ADVISED OF FUTURE TREATMENTS?			
5.	HAS OR IS ANYONE BEEN ADDICTED TO DRUGS OR ALCOHOL, HAS OR IS ANYONE EVER USED DRUGS NOT PRESCRIBED BY A PHYSICIAN? HAS OR IS ANYONE BEEN UNDER A REHABILITATION PROGRAM FOR ADDICTION OR SUBSTANCE ABUSE?			
6.	RECEIVED TREATMENT OR HAS BEEN DIAGNOSED FOR ANY DISORDERS, CONDITIONS OR IS TAKING PRESCRIBED MEDICATION FOR ANY CONDITION NOT MENTIONED ABOVE?			
7.	CURRENTLY IN GOOD HEALTH AND FREE FROM PHYSICAL DEFECT OR INJURIES?			
8.	EVER BEEN DISABLED FOR A PERIOD OF 90 DAYS OR MORE OR MADE A CLAIM ON ANY DISABILITY INSURANCE?			
9.	HAS ANY PERSON ON WHOM COVERAGE IS REQUESTED BEEN DECLINED, POSTPOSED OR RATED IN ANY WAY? Please give details.			
10.	HAS ANY PERSON ON WHOM COVERAGE IS REQUESTED BEEN INVOLVED IN THE OPERATION OF AN AIRCRAFT OR INVOLVED IN ANY HAZARDOUS SPORT? Please give details.			
11.	IS ANYONE PRESENTLY COVERED BY ANOTHER INSURANCE COMPANY FOR EITHER DISABILITY OR AD & D?			
12.	IS ANYONE PRESENTLY COVERED BY ANOTHER INSURANCE COMPANY? IF YES, PLEASE PROVIDE:			
a.	Company's Name:			
b.	Expiration Date of Coverage: _______/__________/_________			
13.	DOES ANY PERSON SOLICITING COVERAGE FOR INSURANCE INTEND TO REPLACE OR CHANGE AN EXISTING POLICY IN CONNECTION WITH THIS APPLICATION? IF YES, PLEASE COMPLETE (a) AND (b) BELOW.			
a.	Company's Name:			
b.	Expiration Date of Coverage: _______/__________/_________			

PLEASE, ATTACH COPY OF THE ACTUAL INSURANCE POLICY AND THE LAST RECEIPT FOR PAYMENT OF THE POLICY, IF REPLACING.

Family or personal physician:	Family or personal physician:
Name:	Name:
Address:	Address:
Phone: Fax:	Phone: Fax:
Email address:	Email address:

Students: Full time students, between the ages of 18 and 23 years old.	
Student's Name	College/University
ATTACH STUDENT STATUS VERIFICATION FORM	

CREDIT CARD PAYMENT AUTHORIZATION	
☐ VISA ☐ MASTERCARD ☐ AMEX ☐ DINERS ☐ OTHER	NAME:
CREDIT CARD NUMBER: __ __ __ __ /__ __ __ __ /__ __ __ __ EXPIRATION DATE: ___ ___ 20____ AMOUNT: US $_______________	ADDRESS:

I, the undersigned, authorize Morgan White Administrators International, Inc. until contrary written notice otherwise, to charge non-specified amounts to my credit card related to my insurance premiums, as and when they become due.

I also authorize Morgan White Administrators International, Inc. until contrary written notice otherwise, to charge non-specified amounts to my credit card related to the payment of the insurance premiums, as and when they become due, for the policies of my following dependents:

Name: ____ Relationship to credit card holder: ____

Date: ____/____/ 20_______ Signature:____

APPLICANT'S STATEMENT

I hereby certify that all responses and declarations contained in this application are true, complete and correct and I understand and agree that any inaccuracy or omission in responses will constitute grounds for the insurer to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the insurer cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or Pre-Existing Conditions, the insurer reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand that the witness receiving this application does not have authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and that all information requested in the application must be set forth in writing on the application. I further understand that this application will become part of the insurance policy to be issued and that the insurer will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand that the witness taking this application from me is the representative of and is acting on my behalf and not the administrator nor the insurance company that is offering this insurance. Neither the administrator nor the company that is offering this insurance, can be held liable for any circumstance if the witness, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator.

It is understood that the insurance applied for shall not become effective until the application is approved and accepted by the insurer, full payment of the first term premium is made and the policy issued subject to all conditions and restrictions contained therein.

I understand that this policy is not available to permanent residents of the United States or others who reside in the United States. However, if any applicant for coverage, who is accepted and insured by the insurer in the applicant's country of residence, moves to the United States of America, the insurer will provide an option to continue insurance coverage.

MEDICAL AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

SIGNATURE OF PROPOSED APPLICANT ______________________________ **DATE** _____/_____/_____
Day Month Year

SIGNATURE OF APPLICANT'S SPOUSE ______________________________ **DATE** _____/_____/_____
(***If to be insured***) Day Month Year

BENEFICIARY DESIGNATION

In the event of the death of any insured, after the policy has been issued, I direct the Company to make payment of any monies due the deceased as follows:	In the event of death of beneficiary
BENEFICIARY	**CONTINGENT BENEFICIARY:**
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Email address:	**Email address:**

THE NAME OF THE WITNESS "IS REQUIRED"

I certify that I have accurately provided all the information given by the applicant and given him/her a copy of the insurance brochure.

______________________ ______________ **Email Address** ______________________
WITNESS **CODE**