HEALTH APPLICATION FORM: NEW WORLD PLAN

APPLICANT'S PERSONAL INFORMATION										
	Name	I.	Last name	Sex	Date of Birth			Age	Height	Weight
					Day	Mth.	Year			
Main										
Spouse										
Child										
Child										
Child										
Child										
Child										
Child										

Permanent Residence(Including City and State):	**Mailing Address:**	**Telephone Number:**
	Email:	**Fax:**
Employer or other postal address	**Occupation and duties:**	**Telephone number:**
	Email:	

	Applicant	**Optional Coverage***	**Premium**
1-			**$**
2-			**$**
3-			**$**
4-			**$**
5-			**$**

MODE OF PAYMENT

☐ Annual ☐ Semi Annual ☐ Monthly

☐ Credit Card ☐ Cheque ☐ Wire Transfer

$10.00 fee applies for wire transfer

Deductible
Plan:

Annual Premium:
Monthly (x0.092+ $2):
Semi Annual (x0.55):

For company use only:

Policy Number:

AFIC H NO PREEX 337

** Additional premium required. Kindly refer to current Rate Table.*

ELIGIBILITY: HEIGHT & WEIGHT CHART

HEIGHT		WEIGHT			
Feet Inches	Meters	Pounds/lbs		Kilograms	
		Min	Max	Min	Max
4'8"	1.42	74	173	33.57	78.47
4'9'	1.45	77	180	34.93	81.65
4'10'	1.47	79	186	35.83	84.37
4'11"	1.50	82	193	37.19	87.54
5'0"	1.52	85	199	38.56	90.26
5'1"	1.55	88	206	39.92	93.44
5'2"	1.57	91	213	41.28	96.62
5'3"	1.60	94	220	42.64	99.79
5'4"	1.63	97	227	44.00	102.97
5'5"	1.65	100	234	45.36	106.14
5'6"	1.68	103	241	46.72	109.32
5'7"	1.70	106	249	48.08	112.94
5'8"	1.73	109	256	49.44	116.12
5'9"	1.75	112	264	50.80	119.75
5'10"	1.78	115	271	52.16	122.92
5'11"	1.80	119	279	53.98	126.55
6'0"	1.83	122	287	55.34	130.18
6'1"	1.85	126	295	57.15	133.81
6'2"	1.88	129	303	58.51	137.44
6'3"	1.91	133	312	60.33	141.52
6'4"	1.93	136	320	61.69	145.15
6'5"	1.96	140	328	63.50	148.78
6'6"	1.98	143	337	64.86	152.86
6'7"	2.01	147	346	66.68	156.94
6'8"	2.03	151	355	68.49	161.03
6'9"	2.06	154	363	69.85	164.65

ELIGIBILITY: Persons who are less than seventy (70) years old and their Dependent(s) and who have been diagnosed or treated for the following conditions: Down's Syndrome, Autism, Epilepsy, Seizure, Paralysis of any kind, Alzheimer's Disease, Dementia, any degenerative neurological disorder, Multiple Sclerosis, Cerebral Palsy, Lou Gehrig's disease, Sickle Cell Anemia, Cystic Fibrosis, Parkinson's disease, Crohn's Disease, Hemophilia, HIV Infection or AIDS, Lupus, Chronic Renal Insufficiency or failure, Schizophrenia, Rheumatoid Arthritis, Chronic Obstructive Pulmonary Disease (COPD), hereditary and congenital disorders or Sicknesses are not eligible for this insurance coverage and will not be covered by this Policy. This Policy is not available to any Permanent Resident of the United States of the America. This Policy has not been filed with or approved by any insurance regulatory authority in the United States of America.

All persons to be insured under this coverage, have read, and understand, that they meet the parameters of the "Height and Weight" and "Eligibility" written on this page.

☐ **Yes**

☐ **No**

Family or personal physician's information	
Name:	Name:
Address:	Address:
Telephone number:	Telephone number:

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 money 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:

APPLICANT'S STATEMENT

I understand that the broker 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 broker 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 broker, 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.

PRE-EXISTING CONDITIONS: means any condition or consequence related to a medical condition, Sickness or Accident for which medical advice, consultation, diagnosis, care or treatment was received, or medications prescribed or taken, within the seven (7) years prior to the Effective Date of this Policy or its Reinstatement or; or (2) a condition that would have caused a prudent person to seek medical advice, consultation, diagnosis, care or treatment prior to the Individual Effective Date of this Policy; or 3) a condition for which medical advice, consultation, diagnosis, care or treatment or any obvious symptom thereof which, if presented to a Physician would have resulted in an attempt to diagnose the condition producing the symptoms prior to the Effective Date of this Policy; or 4) any Covered Charges or Covered Services for Pregnancy within twelve (12) months after the Effective Date of Coverage under this Policy.	I understand ***pre-existing conditions are not covered in this policy.*** ☐ **Yes** ☐ **No**

SIGNATURE OF PROPOSED APPLICANT______________________DATE ____/____/____
Day Month Year

SIGNATURE OF APPLICANT'S SPOUSE ______________________DATE ____/____/____
(If to be insured) Day Month Year

THE NAME OF THE BROKER "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 ________________

COORDINATOR CODE

For any additional information please refer to www.morganwhiteintl.com