Azimuth Risk Solutions℠

THE GLOBAL MARINER APPLICATION

IMPORTANT INFORMATION

This insurance is Primary to P&I (this insurance is Primary to the vessel's Protection and Indemnity Insurance (P&I).

The Global Mariner is intended for the Marine industry. It's intended to cover crew members while working and living on vessels. Global Mariner offers two options: global coverage or global coverage excluding the US and Canada. Both options provide coverage 24 hours a day, 7 days a week, allowing you the freedom to choose any doctor or hospital for your treatment. Please note that the risks and items of insurance covered by this plan are not intended by Underwriters or Azimuth to be a residence, or to be performed in any particular State of the United States, and admission is subject to special requirements. In addition, this insurance is not subject to certain portability, access, renewal, or other requirements of the Federal Health Insurance Portability and Accountability Act (HIPPA). Please read and review all admission requirements, Coverage and pre-existing condition exclusions before contracting coverage. Commercial Brochures and available upon request and a proof of Insurance that contains all the terms of coverage. Please contact Azimuth or your broker / insurance agent for more details.

HOW DO I APPLY?

It's easy, just fax us this completed application at 888-201-8851, or at 317-423-9620 if you are going to pay be credit card.

If you are going to pay with a check, we recommend that you first send the completed application by fax to the number indicated above and then mail the completed application together with the payment to:

Azimuth Risk Solutions
8520 Allison Pointe Blvd, Suite 220
Indianapolis, IN 46250
USA

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Failure to provide information in a complete and legible manner may delay the processing of your Application.

1. In Section 1 clearly write or type your name as you want it to appear on your identification card. In addition, the postal address you provide on the application will be the address to which all correspondence such as the fulfillment kit, continuation of coverage forms and any claim related information will be mailed.
2. Applications must be fully completed, signed and dated for admission to processing. If you answer "YES" to any of the questions in Section 2, you must including the name, address, and phone number of the physician who treated you, the diagnosis, all treatment dates, the type(s) of treatment, prognosis and current line of treatment. (Please use the space provided in Section 3, entitled "Medical / Pre-Insurance Information" to indicate this information). Attach as many additional pages as needed.
3. US Citizens: If you are applying for coverage is living in the US on the date of this application, the effective date of this insurance if there is a day of issuance will be the later of: Date Requested in the application, The date on which the insured person leaves the United States or the date on which the application is accepted by Azimuth and the Proof of Insurance is issued.
4. Non-US Citizens: If you are applying for coverage are living in the United States on the date of this application and have no plans to leave the United States, you must complete an affidavit of eligibility. Your broker / insurance agent can help you in this regard. A new affidavit or eligibility will be required at each continuation of coverage.
5. Annual premiums may be paid by check, money order, bank transfer or Visa, Master Card, American Express or Discover credit card. Azimuth will not accept checks, money orders or bank transfers for semi-annual, quarterly or monthly payments. These alternative modes of payment are only accepted with a prior authorization of charge on your credit card on the due date(s) of your future payment(s) of premium terms, and result in total payments 110%, 112% and 120%, respectively, of the annual premium. You can pay an optional fee of $25 (US) or $35 (outside the US) in addition to the premium so that we send your insurance documentation by express mail once your application is approved.

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SECTION 1 - *Failure to provide all information requested will delay the Application process. Dental Rider - $490 for adult / $325 for child; Sports Rider - $285*

Coverage	Maximum Limit	Deductible	Dental Rider	Sports Rider	Express Delivery
Including US/Canada	☐ $500,000 ☐ $1,000,000	☐ $500 ☐ $1,000 ☐ $2,500	☐ Yes ☐ No	☐ Yes ☐ No	☐ $25 (US) ☐ $35 (All Other)
Excluding US/Canada	☐ $500,000 ☐ $1,000,000	☐ $500 ☐ $1,000 ☐ $2,500	☐ Yes ☐ No	☐ Yes ☐ No	☐ $25 (US) ☐ $35 (All Other)
Requested Effective Date (M/D/Y):			Departure Date (M/D/Y):		

VESSEL INFORMATION - *Please Print*

Name of current or most recent vessel:	Country of registry or Flag:	Email address onboard vessel:	Fax onboard vessel:	I (we) reside and work onboard the vessel: ☐ Yes ☐ No If no, please provide a non-US address below:

APPLICANT - *Please print your name as you would like it to appear on your identification card.*

Name(s) - Last, Middle, First	Sex Male/Female	Height	Weight	Country of Citizenship	Date of Birth(M/D/Y)	Person ID Number(Passport, SSN or DLN)
A.						

NON-US RESIDENCEADDRESS - *Please Print*

Street Address:		
City/State:	Country:	Zip:
Email:	Phone #:	

FORWARDING ADDRESS - ☐ *Same as above*

Address:		
City/State:	Postal Code:	Country:

Is your primary residence, mail forwarding address or do you currently reside in Florida? ☐ Yes ☐ No

(The question above is for Surplus Line Tax determination and does not affect coverage)

STATEMENT OF RESIDENCE

I do herby represent, certify and warrant, I am a professional crew member working aboard a seagoing vessel and expect to spend a significant period of time sailing outside of the U.S. Territorial waters.

a). I reside onboard the above-mentioned vessel, and consider it to be my "residence", as I do not maintain a residence anywhere else. A mail forwarding address is provided below for the purpose of sending and receiving mail and other communications for convenience. This address is not intended to establish or claim residency, or

b). I reside at the Non-US Address above.

This statement must be signed by the applicant, guardian, or proxy. A guardian must be legally authorized to sign on behalf of an applicant, especially when signing for a minor. A guardian includes a parent. A guardian's signature is required for any applicant under the age of seventeen (17). A Proxy is a person authorized by the applicant to act on their behalf. I understand that this insurance is not subject to individual insurance laws of the United States or of any particular State thereof, and that I waive any claim to residency in any State of the United States for purposes of this insurance

Signature of Applicant, Guardian or Proxy: _____ Date (M/D/Y): _____

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SECTION 2 - *If any individual answered â€œYESâ€• to any of the 7 questions below, he or she may NOT qualify for this insurance. Please contact Azimuth Risk Solutions for further assistance. Thank you for the opportunity to serve you.*

1. Are you or any other applicant presently disabled, pregnant or unable to perform normal activities?	☐ Yes ☐ No
2. Are you or any other applicant presently hospitalized, scheduled, in need of Hospitalization or Surgery?	☐ Yes ☐ No
3. Have you or any other applicant ever tested positive for, been diagnosed with, treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeciency Virus (HIV) or any other Immune System Disorder?	☐ Yes ☐ No
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any type of organ transplant (other than corneal)?	☐ Yes ☐ No
5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past twelve (12) months, other than basal cell carcinoma or squamous cell carcinoma?	☐ Yes ☐ No
6. Have you or any other applicant ever been diagnosed with or treated for Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, cerebral palsy, paralysis, or transient cerebral ischemic attacks (as it relates to the conditions listed in this question)?	☐ Yes ☐ No
7. Have you or any other applicant ever been diagnosed with or treated for muscular or skeletal system disorders (including but not limited to: scoliosis, osteoporosis, disc disease, vertebrae or back disease or disorders, rheumatism, fibromyalgia, rheumatoid arthritis, gout, or chronic tendonitis)?	☐ Yes ☐ No

For questions 8-19, below must be answered for the applicant and each family member included on this Application for coverage. For any question answered "YES", please list the family member by using the letter from Section 1, as well as providing complete details of the medical condition in Section 3 of this Application. Please include the name, address and telephone number of the attending physician(s), diagnosis, treatment dates, prognosis and present course of treatment. Azimuth Risk Solutions and Underwriters reserve the right to request additional medical information.

8. If not a US citizen, do you or any other applicant have a US visa or green card?	☐ Yes ☐ No
9. Have you or any other applicant ever been diagnosed with or treated for heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, arteriosclerosis, atherosclerosis, thrombosis, phlebitis, rheumatic fever or chest pain (as it relates to the conditions listed in this question)?	☐ Yes ☐ No
10. Have you or any other applicant been diagnosed with or treated for diabetes or sugar in the blood or urine in the past 10 years?	☐ Yes ☐ No
11. Have you or any other applicant been diagnosed with or treated for epilepsy, convulsions, seizure, stroke, migraines and/or chronic headaches?	☐ Yes ☐ No
12. Have you or any other applicant been diagnosed with or treated for carpal tunnel syndrome and any advanced disease or disorder of the tendons, cartilage, bone or joints?	☐ Yes ☐ No
13. Have you or any other applicant been diagnosed with or treated for thyroid, breast or other glands in the past 10 years?	☐ Yes ☐ No
14. Have you or any other applicant been diagnosed with or treated for elevated blood pressure, hypertension, hypotension, heart murmur, or swelling of the feet or ankles in the past 10 years?	☐ Yes ☐ No
15. Have you or any other applicant consulted a mental health professional or received inpatient or outpatient mental health advice or treatment during the last five (5) years for any mental health condition?	☐ Yes ☐ No
16. Have you or any other applicant experienced a weight change of 20 pounds or more in the last twelve (12) months?	☐ Yes ☐ No
17. Have you or any other applicant used tobacco of any form in the last twelve (12) months?	☐ Yes ☐ No
18. Have you or any other applicant had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any drug or alcohol arrest in the past five (5) years?	☐ Yes ☐ No
19. Have you or any other applicant been diagnosed with or treated for any other disease, medical problem, illness, injury or condition of any kind not listed above?	☐ Yes ☐ No

If any individual answered YES to any of the above questions, he or she may not qualify for this insurance. Please note, coverage may be offered with a Medical Rider or Conditional Rate Up for coverage. All questions answered Yes, must be explained in detail in Section 3 of this Application.

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SECTION 3

- For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1),and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other health care providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Please attach additional pages as necessary. Azimuth reserves the right to request additional medical information prior to acceptance of this Application.

Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone Number	Date(s) of Treatment/Service

MEDICAL RELEASE

MEDICAL RELEASE: hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my care, advice, treatment, diagnosis or prognosis for any physical or mental condition, or financial and employment status, to provide such information to Azimuth Risk Solutions and/or Underwriters and my agent/broker involved in procurement of this application.

ACKNOWLEDGEMENT: understand and agree that: (i) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this Application is acting solely as my legal agent or representative and is representing my personal interest, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of Azimuth or Underwriters, (ii) marketing brochures and Evidence(s) of Insurance wordings are available to us prior to application upon request, (iii) any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the three (3) years prior to the effective date of coverage and time of this insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date herein (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance for a period(s) up to twelve (12), twenty-four (24), or the duration of this insurance, and thereafter, certain benefits and/or all benefits will be reduced as stated in the Evidence of Insurance (available upon request prior to application), and/or the Schedule of Benefits as shown on the brochure and application, (iv) the subjects of insurance applied for are not intended or considered by the applicant(s), Azimuth or Underwriters to be resident, located, or to be performed in any particular state of the United States, and (v) Underwriters, as carrier and Underwriters of the plan, is solely liable for the coverage's and benefits to be provided under this insurance, Azimuth acts solely as an agent/representative for Underwriters and has no independent liability under the Master Policy or any Evidence(s) of Insurance issued by the Master Policy.

CERTIFICATION: hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I have read the questions contained in this Application or that the questions have been read to me, and I understand them, (ii) my responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I will supplement such responses prior to the requested effective date in the event of any change or addition thereto, (iii) I am currently in good health and, except for the conditions and other information disclosed herein, I have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing which I foresee may require treatment in the future or for which I intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

SATISFACTION GUARANTY/REVIEW PERIOD: is understood I will have 7 days from the effective date to review the Evidence of Insurance and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

SUBSCRIPTION: hereby apply for membership in the Beacon/ Axis Series Group Insurance Trust (Anguilla), and for the insurance provided to Participating Member by certain Underwriters at Lloyd's. I understand and agree that (i) no coverage will be effective until this Application has been duly accepted in writing by Azimuth Risk Solutions. (Azimuth), (ii) no modifications or waiver relating to this Application or the coverage applied for will be binding upon Azimuth or Underwriters unless approved in writing by an officer of Azimuth or Underwriters, (iii) Azimuth and Underwriters rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void this insurance, and any and all claims and benefits there under will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I purposefully initiate and take advantage of the privilege of conducting business with Azimuth Risk Solution. a Indiana based company, and registered agent/representative of Certain Underwriters at Lloyd's, London, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Evidence of Insurance shall be deemed issued and made in Indianapolis, Indiana, I understand that Certain Underwriters at Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

Signature of Applicant, Guardian or Proxy:	Date (M/D/Y):

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SECTION 4 - *Premium Calculation (Please note, Applications without payment of premium will not be approved)*

Annual premiums may be paid by check, money order, wire-transfer, or by Visa, MasterCard, American Express, and Discover card. Azimuth will not accept checks, money orders, or wire transfer for semi-annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre-authorization to debit your credit card on the due date (s) of your future premium installment(s) prior to the expiration date. Additional fee(s) may be charged to your credit card if authorized for express delivery of your insurance documents upon request; such fee(s) would be in addition to insurance premium.

(1) Medical Premium	(2) OptionalDental Rider - $490.00	(3) OptionalSports Rider - $285.00	(4) Totals
Please add all totals listed in column number 4 and list total here			$ Subtotal(A)

First Payment Total Due				
Modal Factors (X) (Please choice one)	☐ 1.00 ANNUAL	☐ 0.55 SEMI-ANNUAL	☐ 0.28 QUARTERLY	☐ 0.20 MONTHLY
Subtotal (A) - $	Modal Factor (X) -	Optional Express Mailing Fee - $		Total - $
Total First Payment Due - $				

Future Installment Payments Due (For semi-annual, quarterly, or monthly payment modes)				
Modal Factors (X) (Please choice one)	☐ 1.00 ANNUAL	☐ 0.55 SEMI-ANNUAL	☐ 0.28 QUARTERLY	☐ 0.20 MONTHLY
Subtotal (A) - $	Modal Factor (X) -		Total - $	

Please provide a valid email address in Section 1. All future correspondence regarding monthly, quarterly and semi-annual payments will be made via email to the address provided above in Section 1. If you elect the monthly payment mode, we will draw your first two months during your initial payment, leaving 10 additional monthly payments. During your last month of coverage there will be no payment due.

SECTION 5 - *Method of Payment*

☐ Check (annual only)	☐ Money Order (annual only)	☐ Visa Card	☐ Master Card	☐ American Express Card	☐ Discovery Card

All payments must be made in U.S. dollars. Please make checks and money orders payable to Azimuth Risk Solutions, (Azimuth). If paying by credit card, I authorize Azimuth to debit my Visa card, MasterCard, American Express card, or Discover card account for the total amount due. If I have selected monthly, quarterly, or semi-annual payment modes, I hereby request and authorize Azimuth to debit my credit card account for the proper installment payment due on the due date set forth by Azimuth. This authorization will remain in effect for up to 12 months or as long as I continue to renew my coverage, or until coverage is revoked in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that coverage will not be effective if the credit card company denies the charge. Note: On American Express cards, the CSC is a 4 digit number printed on the front above the account number. On all other cards, it is a 3 digit value printed on the signature panel on the back of the card immediately following the account number, or a portion of the account number.

Name as it appears on card:	Credit Card Number:	
Expiration Date:	Card Security Code (CSC):	Phone #:
Billing Street Address:		
City/State:	Postal Code:	Country:
Authorized Signature:		Date (M,D,Y)

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GLOBAL MARINER RATES

Worldwide Cover - Including the US & Canada/ Annually Renewable Coverage

$500,000 Maximum Limit	
$500 Deductible	$1,391.00
$1,000 Deductible	$1,076.00
$2,500 Deductible	$ 940.00
$1,000,000 Maximum Limit	
$500 Deductible	$1,641.00
$1,000 Deductible	$1,270.00
$2,500 Deductible	$1,110.00

Worldwide Cover - Excluding the US & Canada/ Annually Renewable Coverage

$500,000 Maximum Limit	
$500 Deductible	$1,043.25
$1,000 Deductible	$ 807.00
$2,500 Deductible	$ 752.00
$1,000,000 Maximum Limit	
$500 Deductible	$1,230.75
$1,000 Deductible	$ 953.00
$2,500 Deductible	$ 880.00

I hereby apply for membership in the Beacon/Axis Series Group Insurance Trust (Anguilla) and for the insurance provided to Participating Member by Lloydâ€™s, London. I have personally completed this Application. I represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I understand Azimuth Risk Solutions relies on the information provided on this Application, including any attachments, to determine whether or not the Applicant meets the Underwriting and Eligibility requirements of the plan. I understand that any misrepresentation or omission contained herein will void my insurance and all claims will be forfeited. I understand that this insurance contains Pre-existing condition exclusions, Pre-certification penalties, and other restrictions, exclusions and limitations set forth in the Policy. I understand that I may request a complete copy of the Master Policy at any time and that Azimuth Risk Solution agrees to provide it to me. I understand that if this Application is not accepted, the sole obligation of Azimuth Risk Solutions is to return to me any premium(s) paid. I understand that Certain Underwriters at Lloydâ€™s, London as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I understand that Lloydâ€™s operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand that the insurance Agent or Broker, if any, assisting me with this Application is a representative of me the Applicant. The undersigned authorizes any doctor, medical practitioner, hospital, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator or any other entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition listed on this Application to release said information to Azimuth Risk Solutions.

Signature of Applicant, Guardian or Proxy: ApplicantSignature	Date (M,D,Y):

SECITION 6 *- Insurance Agent/Broker Use Only*

Agent Name: Amanda West	Agent Number: 5231c212
Company Name: PCF Insurance Services of the West	Email: amanda@capitalwestins.com
Company Phone #: 4808682727	Company Fax #:
Email: amanda@capitalwestins.com	Website:
Address: 8501 N Scottsdale Rd.,Suite 200	City, State, Zip: Scottsdale, Arizona, 85253
Agent/Broker Signature:	Date (M,D,Y):