THE MERIDIAN SERIES

APPLICATION

www.azimuthrisk.com

Azimuth
Risk Solutions℠

The Meridian Series Insurance Plan™ is a surplus lines product underwritten by Certain Underwriters at Lloyd's of London. It is distributed, managed and administered, as agent for and on behalf of Underwriters, by Azimuth Risk Solutions (Azimuth).

Important Information

The Meridian Series offers two options: worldwide coverage or worldwide coverage excluding the US and Canada. Both options provide coverage 24 hours a day, 7 days a week allowing you to have the freedom to choose any doctor or hospital for treatment. Please note the risks and subjects of insurance under this plan are not intended or considered by Underwriters or Azimuth to be resident located, or to be performed in any particular State of the United States, and special eligibility requirements apply. Also, this insurance is not subject to certain portability, access, Continuation of Coverage or other requirements of the Health Insurance Portability and Accountability Act of 1996. Please read and review all of the eligibility requirements, coverage conditions, and preexisting condition exclusions carefully before purchasing coverage. Marketing Brochures and Evidence of Insurance containing complete terms of coverage are available upon request. Please contact Azimuth or your independent insurance agent/broker for additional details.

How Do I Apply?

It is easy, simply fax this completed application to 888-201-8851 or 317-423-9620 if paying by credit card.

If paying by check, we recommend first faxing the application to the number above then mailing the completed application and and payment to:

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

Directions for Completing the Application

Failure to provide legible and complete information may delay processing of your Application.

1. In Section 1, print or type your name and the names of all other family members applying for coverage as you want them to appear on your identification card(s). Also, the mail forwarding address provided on your application will be the address where all correspondence will be mailed, such as fulfillment kit, Continuation of Coverage forms, and any claim information.

2. All Applications must be fully completed, signed and dated to be considered. If any questions are answered "Yes" in Section 2, you must identify the family member(s) to whom the "Yes" answer applies, and include the name, address and telephone number of the attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. (Please use the space provided in Section 3, entitled "Medical Information/Prior Insurance," to provide this information). Please attach additional pages as necessary

3. US Citizens: If you or any family member applying for coverage is located in the US on the date of this application, the Effective Date of this insurance will be the later of: (i) The effective date requested on the application; or (ii) The date the insured person departs the US; or (iii) The date the application is accepted by Azimuth and an Evidence of Insurance issued.

4. Non-US Citizens: If you or any family member applying for coverage is located in the US on the date of this application and do not plan to depart the US, an affidavit of eligibility must be completed. Your insurance agent/broker can assist you in this regard. A new affidavit of eligibility will be required at each Continuation of Coverage.

5. Annual premiums may be paid by check, money order, wire transfer, or by Visa, Master Card, American Express, and Discover credit cards. Azimuth will not accept checks, money orders or wire transfers 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), and result in total payments of 110%, 112%, and 120%, respectively, of the annual premium. An optional $25 (US) or $35 (non-US) fee may be paid in addition to the premium to have your insurance documents express mailed to you after your application has been approved.

THE MERIDIAN SERIES APPL

Going Your Way

Azimuth
Risk Solutions

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Azimuth Risk Solutions, LLC
1 North Pennsylvania Street, Ste 600
Indianapolis, IN 46204
USA

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SECTION 1

Please complete for all Family Members applying for coverage. Failure to provide all information requested will delay the app

☐ Meridian Series- Enhanced			☐
Coverage Area	Deductibles	Dental Rider	Spo
Including US/Canada	$ 2,500.00	No	
Excluding US/Canada	$ 2,500.00	No	
Requested Effective Date: 12/01/2013			Departure Date: 12/0

Please print your name and all family member(s) names as you would like it to appear on your identification card. Please
Beacon/Axis Series Group Insurance Trust (Anguilla).

NAME Please print your name below	Sex	Height	Weight
A. Applicant(Carroll Kathleen Lynn)	female	5 feet 10 inches	142 pounds
B. Spouse (------ ------ ------ ------)	------	------	------
C. (------ ------ ------)	------	------	------
D. (------ ------ ------)	------	------	------
E. (------ ------ ------)	------	------	------
F. (------ ------ ------)	------	------	------
G. (------ ------ ------)	------	------	------
H. (------ ------ ------)	------	------	------
I. (------ ------ ------)	------	------	------
J. (------ ------ ------)	------	------	------

RESIDENCE ADDRESS	
STREET ADDRESS: Camino Cieneguita km 4 ------	
COUNTRY: Mexico	TELEPHONE: 408-656-6894

IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE U.S. AT LEAST 6 OF THE NEXT 12 MONTHS? Yes **(IF A NON-U.S. CITIZEN AND YOUR RESIDENCE ADDRESS IS THE U.S. AND YOU ANSWERED "NO" TO THE ABOVE QUESTI** **ELIGIBILITY MUST BE COMPLETED).**	
MAIL FORWARDING ADDRESS	
STREET ADDRESS: 1703 Chestnut Street	CITY: Berkeley
STATE, COUNTRY: California United States	TELEPHONE: 408-656-6894
EMAIL: katcar0001@gmail.com	
IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENTLY LO No	
THE ABOVE QUESTION IS FOR SURPLUS LINES TAX DETERMINATION A	

SECTION 2

Please answer all questions for the Applicant and for each Family Member applying for coverage. For any question answered Yes, plea Section 3 of this Application.
1. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?
2.Are you or any other applicant pregnant or have an adoption pending?
3. Are you or any other applicant currently disabled or unable to perform normal activities?
4. Do you or any other applicant participate in professional sports?
5. 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)?
6. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AID Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?
If any individual answered YES to any of the above six questions, he or she does NOT qualify for this insurance. Please contact Azim to serve you.
7. If a non-U.S. citizen, have you or any other applicant resided continuously inside the U.S. for the last (5) years?
8. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past (5) years? If explain in section 3 of this application.
9. Have you or any other applicant ever been diagnosed with or treated for diabetes, hyperglycemia, hypoglycemia, or sugar in the blood or urine please explain in section 3 of this application. You may be required to complete a diabetes questionnaire.

If any individual answered YES to any of the above three questions, he or she may not qualify for this insurance.
For questions 10-30, below must be answered for the applicant and each family member included on this Application for coverage. F the answer applies by using the corresponding letter from Section 1 of this Application, and provide complete details of the medical c telephone number of attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of t request additional medical information.
10. During the last twelve (12) months, have you or any other applicant experienced manifestation or symptoms of, been diagnosed with, or rece consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition?
11. During the last twelve (12) months, have you or any other applicant experienced a weight change of 20 pounds or more?
12. During the last twenty-four (24) months, have you or any other applicant used tobacco of any form? If yes, please indicate type and frequency of this application.
13. During the last five (5) years, have you or any other applicant had any indication, diagnosis or treatment of an alcohol or drug dependency, p abuse or any drug or alcohol related arrest?
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, illness, medical problem, disorder, sickness or other problem arising from, involving, or relating to any of the following:

14. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, chest pain, arteric elevated blood pressure, hypertension, hypotension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur?
15. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, ly high cholesterol?
16. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?
17. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down syndrome, or other chr disorder, physical disorder, deformity or defect?
18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's dise epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?
19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?
20. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid, metabolic disorders, or obesity?
21. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleuri
22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or depe alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?
23. Kidney, urinary tract functions, kidney or bladder stones or infections?
24. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or breast cysts, fallopia ovaries or uterus?

SECTION 2 (Continued)

25. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?
26. Sexually transmitted disease (STD)?
27. Digestive system, stomach, or intestines, including but not limited to: esophageal, regurgitation, gastritis, ulcers, colon, or rectum disorder?
28. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?
29. Any other disease, medical problem, illness, injury or condition of any kind not listed above?
30. Have you or any other applicant been covered under any other health or medical insurance plan during the last twelve (12) months? If yes, pl name and location of the insurance company, the policy number or plan number, and the dates of coverage below:

Co. Name & Location:: HCC Medical Ins.	**Policy/Plan # : 3190744**

SECTION 3

Medical Information

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresp
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 tre
additional medical information prior to acceptance of this Application.

Family Member (use letters from Section 1)	**Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)**	**Physician/ Care Provid Tele**
A	**Conditions:**Hiatal hernia **Diagonosis:**Antiacids Diet	**Dr name:**Hospital la Fe **Dr. Address:**San Miguel Alle **Dr. Phone:**415-152-2222
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MEDICAL RELEASE: I (we) hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related fa policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or provide such information to Azimuth Risk Solutions, LLC. and/or Underwriters and my agent/broker involved in procurement

ACKNOWLEDGEMENT: I (we) understand and agree that: (i) the insurance agent, broker, website, or other producer, if any agent or representative and is representing my (our) personal interest, and that such person has no authority to bind Underwriters, (ii) marketing brochures and Evidence(s) of Insurance wordings are available to us prior to application upon r nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application or at any t insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there disclosed prior to the effective date herein (a "pre-existing condition"), and that all charges and/or claims for pre-existing twelve (12), twenty-four (24), or the duration of this insurance, and thereafter, certain benefits and/or all benefits will b application), and/or the Schedule of Benefits as shown on the brochure and application, (iv) the subjects of insurance applie resident, located, or to be performed in any particular state of the United States, and (v) Underwriters, as carrier and Under this insurance, Azimuth acts solely as a agent/representative for Underwriters and has no independent liability under the Mas

CERTIFICATION: I (we) hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I (we) have read the qu and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of t effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the c sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from ar (we) intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act

SATISFACTION GUARANTY/REVIEW PERIOD: It is understood I (we) will have 7 days from the effective date to review th of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date ar

SUBSCRIPTION: I (we) hereby apply for membership in the Beacon/ Axis Series Group Insurance Trust (Anguilla), and for (we) understand and agree that (i) no coverage will be effective until this Application has been duly accepted in writing by Application or the coverage applied for will be binding upon Azimuth or Underwriters unless approved in writing by an office completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void this insur by submission of this Application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the company, and registered agent/representative of Certain Underwriters at Lloyd's, London, and invoke the benefits and prote and evidenced by the Evidence of Insurance shall be deemed issued and made in Indianapolis, Indiana, I (we) understand coverage and benefits provided under this insurance. I (we) understand that Lloyd's operates as an approved, non-admitte admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree th of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer t

Kathleen L. Carroll
Signature of Applicant, Guardian or Proxy

Signature of Spouse

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 annual, quarterly, or monthly payment modes. These alternative payment modes are only accepted with pre-authorization to debit you to the expiration date. Additional fee(s) may be charged to your credit card if authorized for express delivery of your insurance docume

	(1) MEDICAL PREMIUM	(2) OPTIONAL DENTAL RIDER	
A. Applicant	$ 897	$ 0	$ 0
B. ------	$ ------	$ ------	$ --
C.	$ ------	$ ------	$ --
D.	$ ------	$ ------	$ --
E.	$ ------	$ ------	$ --
F.	$ ------	$ ------	$ --
G.	$ ------	$ ------	$ --
H.	$ ------	$ ------	$ --
I.	$ ------	$ ------	$ --
J.	$ ------	$ ------	$ --

OPTIONAL MATERNITY RIDER (APPLIES ONLY TO MERIDIAN BASIC PLAN OPTION). PLEASE CHECK HERE IF PURCHASING THE MA

Please add all totals listed in column

First Payment Total Due

Modal factors: Annual=1.00

(Please select a payment mode)

$ 897 + 0.00 (StateTax) (Subtotal A)	X 1.00 *Modal Factor	= $ 897.00 + Optional express mailing fee ($25 in US, $35 outside Total

Total First Payment Due: $ 897

Future Installment Payment s Due (For semi-annual, quarterly or monthly payment modes)

Modal factors: Annual=1.00

(Please select a payment mode)

$ 897 + 0.00 (StateTax)	X 1.00	= $ 897.00
(Subtotal A)	*Modal Factor	Total Premium due for all remaining payments

Please provide a valid email address in Section 1. All future correspondence regarding monthly, quarterly and semi-annual payment elect the monthly payment mode, we will draw your first two months during your initial payment, leaving 10 additional monthly payme

SECTION 5.

☐ **Check/Money Order**	
☑ **Visa Card**	☐ **M**
☐ **American Express Card**	☐ **Di**

All payments must be made in U.S. dollars. Please make checks and money orders payable to Azimuth Risk Solutions, LLC. (Azimuth). If American Express card, or Discover card account for the total amount due. If I have selected monthly, quarterly, or semi-annual payment modes 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 Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that coverage will not be 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 sign portion of the account number.

Name as it appears on card: Kathleen L Carroll	**Billing Address: 1703 Chestnut**
Credit Card Number: XXXXXXXXXXXX9824	**Expiration Date: 05-2015**
Daytime Phone Number: 408-656-6894	**Authorized Signature: Kathleen**

I (we) hereby apply for membership in the Beacon/Axis Series Group Insurance Trust (Anguilla) and for the insurance provided to Participatin (we) represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I (we) understand including any attachments, to determine whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I (we) u insurance and all claims will be forfeited. I understand that this insurance contains Preexisting condition exclusions, Pre-certification penalties, 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 return to me any premium(s) paid. I (we) understand that Certain Underwriters at Lloyd's, London as underwriter of the plan, is solely liable f Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky, where they are admitted fund. I (we) understand that the insurance Agent or Broker, if any, assisting me (us) with this Application is a representative of me (us) the Ap health facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, or insurance or benefit administrator physical or mental condition of any Family Member listed on this Application to release said information to Azimuth Risk Solutions, LLC.

Kathleen L. Carroll
Signature of Applicant, Guardian or Proxy

Signature of Spouse

SECTION 6.

Insurance Agent/Broker Use Only

Azimuth Agent Number: 51074ed9	**Azimuth Agent Name: Expa**
Company Name: ExpatGlobalMedical.com	
Company Address: 106 Keswick Drive,First Floor	**City, State, Postal Code: Ad**
Phone: 336-998-9583	**Fax:**
Website: http://www.expatglobalmedical.com/	**Email: john@expatglobalm**
Agent/Broker Signature:	

1 North Pennsylvania Street, Ste 600
Indianapolis, Indiana 46204

Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851

Em
We

Azimuth Risk Solutions™

www.azimuthrisk.com

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