

THE MERIDIAN SERIES

APPLICATION



Coverage Anywhere.  
Value Everywhere.

[www.azimuthrisk.com](http://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 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



## THE MERIDIAN SERIES APPLICATION

**The Meridian Series Insurance Plan<sup>SM</sup> is a surplus lines product underwritten by C distributed, managed and administered, as agent for and on behalf of Underwriters**

### Important Information

The Meridian Series offers two options: worldwide coverage or worldwide coverage excluding the U.S. 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, renewal 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 recomend first faxing the application to the number above then mailing the completed application and and payment to:**

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

### Directions

Failure to p

1. In Sectio  
coverage a  
provided o  
fulfillment k

2. All Appli  
answered '  
applies, an  
all treatment  
space provi  
Please attar

3. U.S. Citiz  
this applica

(i) The effe  
or (iii) The c

4. Non-U.S.  
date of this  
Your insura  
each renew

5. Annual  
American E  
transfers fo  
only accept  
installment  
premium. A  
your insura





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 QUESTION, YOUR MAIL FORWARDING ADDRESS AND TELEPHONE NUMBER FOR MAIL FORWARDING ADDRESS ELIGIBILITY MUST BE COMPLETED).

**MAIL FORWARDING ADDRESS**

STREET ADDRESS: Toronato Pastc

CITY: Abaco

STATE, COUNTRY: Hope Town Bahamas The

TELEPHONE: 242-366-0256

EMAIL: -----

IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENTLY LIVING IN FLORIDA?  
No

**THE ABOVE QUESTION IS FOR SURPLUS LINES TAX DETERMINATION**



---

## SECTION 2

**Please answer all questions for the Applicant and for each Family Member applying for coverage. For any question answered Yes, please refer to 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 (AIDS), 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 yes, please 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? If yes, 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. For each question, the answer applies by using the corresponding letter from Section 1 of this Application, and provide complete details of the medical condition, telephone number of attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. If you 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 received 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 use 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, problem, 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, diagnosis, 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, arterial 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, lymphoma, 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 chromosomal 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 disease, 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 bone 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, pleurisy?

22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependence, 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, fallopian tubes, ovaries or uterus?





MEDICAL RELEASE: I (we) hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis to provide such information to Azimuth Risk Solutions, LLC. and/or Underwriters and my agent/broker involved in procurement of this insurance.

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

CERTIFICATION: I (we) hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I (we) have read the questions and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the effective date in the event of any change or addition thereto, (iii) I am (we are) currently in good health and, except for the conditions sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any condition that I (we) intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the undersigned 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 the terms of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and without penalty.

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

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

	(1) MEDICAL PREMIUM	(2) OPTIONAL DENTAL RIDER	
A. Applicant	\$ 2314	\$ 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 MATERNITY RIDER.**

Please add all totals listed in column

### First Payment Total Due

**Modal factors:** Annual=1.00

**(Please select a payment mode)**

\$ 2661.1 + 0.00 (StateTax) X 1.00 = \$ 2,661.10 + Optional express mailing fee (\$25 in US, \$35 outside US)  
 (Subtotal A) \*Modal Factor Total

**Total First Payment Due: \$ 2661.1**

### Future Installment Payments Due (For semi-annual, quarterly or monthly payment modes)



**Modal factors:** Annual=1.00

**(Please select a payment mode)**

\$ 2661.1 + 0.00 (StateTax) X 1.00 = \$ 2,661.10  
(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 payments. Please select the monthly payment mode, we will draw your first two months during your initial payment, leaving 10 additional monthly payments.**

## SECTION 5.

**Check/Money Order**

**Visa Card**

**American Express Card**

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

**Name as it appears on card: Kent W LeBoutillier**

**Billing Address: Toronato Past**

**Credit Card Number: XXXXXXXXXXXX7095**

**Expiration Date: 12-2014**

**Daytime Phone Number: 242-366-0256**

**Authorized Signature: Kent W L**

I (we) hereby apply for membership in the Beacon/Axis Series Group Insurance Trust (Anguilla) and for the insurance provided to Participating Members. I (we) represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I (we) understand that Azimuth Risk Solutions, LLC. (Azimuth) is the insurance agent and will be responsible for determining whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I (we) understand that if I (we) do not pay the premium(s) on time, my (our) insurance and all claims will be forfeited. I understand that this insurance contains Preexisting condition exclusions, Pre-certification penalties, and 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 I (we) do not pay the premium(s) on time, I (we) will not be entitled to a refund of any premium(s) paid. I (we) understand that Certain Underwriters at Lloyd's, London as underwriter of the plan, is solely liable for the plan. 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 licensed agents. I (we) understand that the insurance Agent or Broker, if any, assisting me (us) with this Application is a representative of me (us) the Applicant(s). I (we) understand that the insurance Agent or Broker, if any, assisting me (us) with this Application is a representative of me (us) the Applicant(s) and will not release any physical or mental condition of any Family Member listed on this Application to release said information to Azimuth Risk Solutions, LLC.

Kent W LeBoutillier  
Signature of Applicant, Guardian or Proxy

-----  
Signature of Spouse

## SECTION 6.

### Insurance Agent/Broker Use Only

Azimuth Agent Number: 91f036ef	Azimuth Agent Name: Adam
Company Name: Insurance Services of America, Inc.	
Company Address: 1757 E. Baseline Road,Suite 126	City, State, Postal Code: G
Phone: 480-821-9052	Fax: 480-821-9297
Website: <a href="http://www.overseashealth.com/">http://www.overseashealth.com/</a>	Email: adam@isabrokers.c
Agent/Broker Signature:	





 **Azimut**  
Risk Solutions

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





[www.azimuthorisk.com](http://www.azimuthorisk.com)

8520 Allison Pointe Blvd, Suite 220 • Indianapolis, Indiana 46250  
Phone: 317-644-6291 / 888-201-8850 • Fax: 317-423-9620 / 888-201-8851  
Email: [service@azimuthorisk.com](mailto:service@azimuthorisk.com) • Website: [www.azimuthorisk.com](http://www.azimuthorisk.com)