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.

SECTION 1

SECTION 2

COUNTRY: Bahamas The	TELEPHONE: 242-366-0256	I would like to receive my insurance documents electronically

IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE US AT LEAST 6 OF THE NEXT 12 MONTHS? Yes

(If a Non-US Citizen and your residence address is the US And you answered "no" to the above question, or the residence address is not completed, an affidavit of eligibility must be completed).

MAIL ORDERING ADDRESS

STREET ADDRESS: Toronato Pastc

CITY, STATE, COUNTRY: Abaco Hope Town Bahamas The

COVERAGE

2. Are you or any other applicant pregnant or have an adoption pending?	No--
3. Are you or any other applicant currently disabled or unable to perform normal activities?	No--
4. Do you or any other applicant participate in professional sports?	No--
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)?	No--
6. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other Immune System Disorder?	No--

If any individual answered YES to any of the above six questions, he or she does NOT qualify for this insurance. Please contact Azimuth Risk Solutions, For further assistance. Thank you for the opportunity to serve you.

7. If a non-US citizen, have you or any other applicant resided continuously inside the US for the last (5) years?	No--
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.	No--
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.	No--

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 any question answered "YES," please indentify the family member to whom the answer applies by using the corresponding letter from Section 1 of this Application, and provide complete details of the medical condition at issue in Section 3 of this Application, including name, address, and telephone number of attending physician(s), diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. Azimuth Risk Solutions and Underwriters reserve the right to 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 any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition?	No--
11. During the last twelve (12) months, have you or any other applicant experienced a weight change of 20 pounds or more?	No--
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 in section 3 of this application.	No--
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 or abuse or any drug or alcohol related arrest?	No--

Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, examination, testing or been treated for, or been diagnosed with, any disease, condition, 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, arteriosclerosis, elevated blood pressure, hypertension, hypotension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur?	No--
15. Blood, blood vessels, spleen, arteries, veins or disorders of the blood, including, but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	No--
16. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	No--

17. Congenital, genetic, hereditary or other birth condition or defect including, but not limited to: mental retardation, Down syndrome, or other chromosome disorder, physical disorder, deformity or defect?	~~No~~--
18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	~~No~~--
19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?	~~No~~--
20. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid, metabolic disorders, or obesity?	~~No~~--
21. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	~~No~~--
22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	~~No~~--
23. Kidney, urinary tract functions, kidney or bladder stones or infections?	~~No~~--
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?	~~No~~--
25. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	~~No~~--
26. Sexually transmitted disease (STD)?	~~No~~--
27. Digestive system, stomach, or intestines, including but not limited to: esophageal, regurgitation, gastritis, ulcers, colon, or rectum disorder?	~~No~~--
28. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	~~No~~--
29. Any other disease, medical problem, illness, injury or condition of any kind not listed above?	~~No~~--
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, please state the name and location of the insurance company, the policy number or plan number, and the dates of coverage below:	~~X~~es

SECTION 3

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

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(use letters from Section 1)	**Prognosis, Past and Present Course of Treatment(s)**	**Care Provider Name(s), Address & Telephone Number**	**Treatment/Service** ------
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MEDICAL RELEASE: I (we) 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 (our) 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.

SECTION 4

SECTION 5

Company Address: 5218 S East St, Suite E-1,	City, State, Postal Code: Indianapolis Indiana, 46227
Phone: 888-201-8850	Fax: 866-201-6885
Website:	Email: service@azimuthrisk.com
Agent/Broker Signature:	

on the information provided on this Application, including any attachments, to determine whether or not the Applicant(s) meets the Underwriting and Eligibility requirements of the plan. I (we) understand will be forfeited. I understand that this insurance contains Preexisting 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 (we) understand that Certain Underwriters at Lloyd's, London as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I (we) 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 (we) understand that the insurance Agent or Broker, if any, assisting me (us) with this Application is a representative of me (us) 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 tothe care, advice, treatment, diagnosis, or physical or mental condition of any Family Member listed on this Application to release said information to Azimuth Risk Solutions.

Signature of Applicant, Guardian or Proxy
Kent W LeBoutillier

Date (Mo./Day/Yr.)

Signature of Spouse

Date (Mo./Day/Yr.)

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