

THE MERIDIAN SERIES

APPLICATION



Coverage Anywhere.
Value Everywhere.

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.

SECTION 1

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

<input type="checkbox"/> Meridian Series- Enhanced			<input checked="" type="checkbox"/> Meridian Series- Essential	
Coverage Area	Deductibles	Dental Rider	Optional Extream Sports Rider	Express Delivery \$ 25.00 (US) \$ 35.00 (All Others)
Including US/Canada	\$ 10,000.00	No	No	\$ 0.00
Excluding US/Canada	-----	-----	-----	-----
Requested Effective Date: 05/02/2023			Departure Date: 05/02/2023	

Please print your name and all family member(s) names as you would like it to appear on your identification card. Please ONLY include the names of those family members applying for coverage under the Beacon/Axis Series Group Insurance Trust (Anguilla).

NAME Please print your name below	Sex	Height	Weight	Date of Birth Mo/Day/Yr.	Country of Citizenship	Personal Identification Number (Passport, SS# or DL#)
A. Applicant(Humphreys Ronald -----)	male	5 feet 9 inches	170 pounds	11/03/1965	United States	643055214
B. Spouse(Croteau Aimee -----)	female	5 feet 3 inches	120 pounds	12/15/1977	United States	AK332367
C. (Humphreys Hunter -----)	male	3 feet 0 inches	40 pounds	02/08/2019	United States	A07122761
D. (Humphreys Bodhi -----)	male	1 feet 0 inches	28 pounds	04/11/2022	United States	A07122762
E. (-----)	-----	-----	-----	-----	-----	-----
F. (-----)	-----	-----	-----	-----	-----	-----
G. (-----)	-----	-----	-----	-----	-----	-----
H. (-----)	-----	-----	-----	-----	-----	-----
I. (-----)	-----	-----	-----	-----	-----	-----
J. (-----)	-----	-----	-----	-----	-----	-----

RESIDENCE ADDRESS		
STREET ADDRESS: 73-4682 KOHANAIKI RD, -----	CITY, STATE, POSTAL CODE: KAILUA KONA Hawaii 96740	
COUNTRY: United States	TELEPHONE: 8086450612	I would like to receive my insurance documents electronically (please check the box to receive your documents by email)Yes
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 FORWARDING ADDRESS		
STREET ADDRESS: 73-4682 KOHANAIKI RD,	CITY, STATE, COUNTRY: Kailua Kona Hawaii United States	
EMAIL: aimeecroteau@gmail.com	TELEPHONE: 8086450612	
IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENTLY LOCATED IN FLORIDA? -----		
THE ABOVE QUESTION IS FOR SURPLUS LINES TAX DETERMINATION AND DOES NOT AFFECT COVERAGE		

SECTION 2

Please answer all questions for the Applicant and for each Family Member applying for coverage. For any question answered Yes, please explain in Section 3 of this Application.	If Yes, show family member by using letters from Section 1
1. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	No -----
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 -----
<i>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.</i>	
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 -----
<i>If any individual answered YES to any of the above three questions, he or she may not qualify for this insurance.</i>	
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 identify 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' 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' disease (ALS), Parkinson' 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:	No -----
Co. Name & Location:	Policy/Plan # :
	Date(s) of Cover:

SECTION 4

Premium Calculation (Please see the Meridian Series Rate sheet for Premium and Optional Rider Cost)

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.

APPLICANT	(1) MEDICAL PREMIUM	(2) OPTIONAL DENTAL RIDER	(3) OPTIONAL EXTREAM SPORTS RIDER	(4) TOTAL
A. _____	\$ 1886	\$ 0	\$ 0	\$ 1886
B. _____	\$ 1423	\$ 0	\$ 0	\$ 1423
C. _____	\$ 0	\$ 0	\$ 0	\$ 0
D. _____	\$ 0	\$ 0	\$ 0	\$ 0
E. _____	\$ -----	\$ -----	\$ -----	\$ -----
F. _____	\$ -----	\$ -----	\$ -----	\$ -----
G. _____	\$ -----	\$ -----	\$ -----	\$ -----
H. _____	\$ -----	\$ -----	\$ -----	\$ -----
I. _____	\$ -----	\$ -----	\$ -----	\$ -----
J. _____	\$ -----	\$ -----	\$ -----	\$ -----

Please add all totals listed in column number 4 and list total here $\frac{\$ 3309 + 0 \text{ (StateTax)}}{\text{(Subtotal A)}}$

First Payment Total Due

Modal Factors: Monthly=0.20

(Please select a payment mode)
 In US Out US

$$\frac{\$ 3309 + 0 \text{ (StateTax)}}{\text{(Subtotal A)}} \times \frac{0.20}{\text{*Model Factor}} = \frac{\$ 661.8}{\text{Total}} + \text{Optional express mailing fee } (\$ 25.00 \text{ in US, } \$ 35.00 \text{ outside US): } \$ \text{ -----}$$

Total First Payment Due: \$ 661.8

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

Modal Factors: Monthly=0.10

(Please select a payment mode)

$$\frac{\$ 3309 + 0 \text{ (StateTax)}}{\text{(Subtotal A)}} \times \frac{0.10}{\text{*Model Factor}} = \frac{\$ 330.9}{\text{Total Premium due for all remaining payments}}$$

Please provide a valid email address in Section 1. All future correspondence regarding monthly, quarterly and semi-annual payments 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. **(Please note, Applications without payment or premium will not be approved).**

SECTION 5

Cheque/Money Order

Visa Card

Master Card

American Express Card

Discover 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 (we) 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 (we) 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 (we) continue to renew my (our) 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: Aimee Croteau

Billing Address: 73-4682 KOHANAIKI RD, KAILUA KONA, Hawaii, United States, 96740

Credit Card Number: XXXXXXXXXXXX9266

Expiration Date: 11/2026
Card Security Code(CSC): XXX

Daytime Phone Number: 8086450612

Authorized Signature: Aimee croteau

I (we) hereby apply for membership in the Beacon/Axis Series Group Insurance Trust (Anguilla) and for the insurance provided to Participating Members by Lloyd', London. I (we) have personally completed this Application. I (we) represent and warrant that the answers and statements on this Application are true, complete and correctly recorded. I (we) understand Azimuth Risk Solutions relies 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 that any misrepresentation or omission contained herein will void my (our) insurance and all claims 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', London as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. I (we) understand that Lloyd' 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 to the 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.

Aimee croteau

Signature of Applicant, Guardian or Proxy

Date (Mo./Day/Yr.)

Signature of Spouse

Date (Mo./Day/Yr.)

Insurance Agent/Broker Use Only

Azimuth Agent Number: 4d346482

Azimuth Agent Name: Health Insurance Services International (Health Insurance Services International)

Company Name: Health Insurance Services International

Company Address: 438 Retaheim Way,

City, State, Postal Code: La Jolla California, 92037

Phone: 858-750-9080

Fax: 858-404-9295
Country: United States

Website: <http://www.healththisinternational.com/>

Email: arno@healththisinternational.com

Agent/Broker Signature:



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