COBERTURA ELITE APPLIC

Going Your Way

THE COBERTURA ELITE APPLICAT

The Cobertura Elite Insurance Plansm is a product underwritten by Certain Underw
and administered, as agent for and on behalf of Underwriters, by Azimuth Risk Sol

Important Information **Directi**

The Cobertura Elite Plan 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 pre-existing 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.

Eligibility

In order to be eligible and qualified for coverage under this insurance, a Participating Member must:

1.Complete and sign an Application (or be listed thereon by proxy as an applicant and proposed Participating Member) with all questions answered truthfully and completely; and

2. Pay the required Premium on or before the Due Dates.

3.Present the declaration page of prior coverage under his/her local country coverage plan for the prior 12 months (Creditable Coverage), including proof of purchase, and coverage dates.

4.Receive written acceptance of his/her Application or renewal from the Scheme Administrator.

5.Be at least fourteen (14) days old but not yet seventy-five (75) years old.

6.Not be Pregnant, Hospitalized or disabled on the Initial Effective Date.

7.Not be HIV+ on the Initial Effective Date.

8.US Citizens: if a United States citizen, must be residing outside of the USA as of the Effective Date (or renewal date) and plan to reside outside of the USA for at least six (6) of the next twelve (12) months thereafter.

9.Non-US Citizens: must reside outside the USA at time of Application (or renewal); or must plan to reside outside of the USA continuously for at least six (6) months during the Period of Insurance with departure from the US not more than thirty (30) days after the Initial Effective Date or renewal effective date; or if located inside the USA at the time of Application (or renewal), must not be eligible for any other medical insurance plan which is available to individuals similarly situated and located in the US and must provide the Scheme Administrator an Affidavit of Eligibility.

Note: If a Participating Member is not eligible, the Evidence of Insurance issued by the Master Policy

SECTION 1

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

Cobertura Elite		
Coverage Area	Deductibles	
Including US/Canada	☐ ☐ $ 10,000 $ 20,000	☐ ☐
Excluding US/Canada	☐ ☐ $ 10,000 $ 20,000	☐ ☐
Requested Effective Date:		Depa

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 (Last, First, Middle)	☐Male ☐Female		
B. Spouse (Last, First, Middle)	☐Male ☐Female		
C. (Last, First, Middle)	☐Male ☐Female		
D. (Last, First, Middle)	☐Male ☐Female		
E. (Last, First, Middle)	☐Male ☐Female		
F. (Last, First, Middle)	☐Male ☐Female		
G. (Last, First, Middle)	☐Male ☐Female		

H. (Last, First, Middle)	☐Male ☐Female			
I. (Last, First, Middle)	☐Male ☐Female			
J. (Last, First, Middle)	☐Male ☐Female			

RESIDENCE ADDRESS	
STREET ADDRESS:	
COUNTRY:	TELEPHONE:
IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE U.S. AT LEAST 6 OF THE NEXT 12 MONTHS? (IF A NON-U.S. CITIZEN AND YOUR RESIDENCE ADDRESS IS THE U.S. AND YOU ANSWERED "NO" TO THE ABOV AFFIDAVIT OF ELIGIBILITY MUST BE COMPLETED).	
	MAIL FORWARDING ADDRESS
STREET ADDRESS:	CITY:
STATE, COUNTRY, POSTAL CODE:	TELEPHONE:
EMAIL:	
IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURI : ☐Yes ☐No	
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.
1. Are you or any other applicant currently disabled, pregnant, or unable 1. to perform normal activities?
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Sy (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or any other immune sys
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transpla
5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past t months, other than basal cell carcinoma or squamous cell carcinoma?
6. Have you or any other applicant ever been diagnosed with or treated for Neurological disorders, including but not limited to: multipl (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, cerebral palsy, paralysis, or transient cerebral ischemic relates to the conditions listed in this question)?
7. Have you or any other applicant ever been diagnosed with or treated for muscular or skeletal system disorders (including but not li scoliosis, osteoporosis, disc disease, vertebrae or back disease or disorders, rheumatism, fibromyalgia, rheumatoid arthritis, gout, or tendonitis)?
If any individual answered YES to any of the above questions, he or she does not qualify for this insurance. Thank you for y answered No to all the above questions, Please continue with the questions below.
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.
8. Have you or any other applicant ever been diagnosed with or treated for heart, cardiac, cardiovascular and/or circulatory, including limited to: congestive heart failure, heart attack, angina, arteriosclerosis, atherosclerosis, thrombosis, phlebitis, rheumatic fever or che relates to the conditions listed in this question)?
9. 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?
10 .Have you or any other applicant been diagnosed with or treated for epilepsy, convulsions, -seizure, stroke, migraines and/or chro
11. Have you or any other applicant been diagnosed with or treated for carpal tunnel syndrome -and any advanced disease or disord tendons, cartilage, bone or joints?
12. Have you or any other applicant been diagnosed with or treated for thyroid, breast or -other glands in the past 10 years?
13. Have you or any other applicant been diagnosed with or treated for Elevated blood -pressure, hypertension, hypotension, heart m swelling of the feet/ankles in -the past 10 years?

14. Have you or any other applicant consulted a mental health professional or received -inpatient or outpatient mental health advice c during the last five (5) years -for any mental health condition?
15. Have you or any other applicant experienced a weight change of 20 pounds or more in -the last twelve (12) months?
16. Have you or any other applicant used tobacco of any form in the last twelve (12) -months?
17. Have you or any other applicant had any indication, diagnosis or treatment of an -alcohol or drug dependency, problem or abuse alcohol arrest in the past -five (5) years?
18. Have you or any other applicant been diagnosed with or treated for any other disease, -medical problem, illness, injury or conditic not listed above?
If any individual answered YES to any of the above questions, he or she may not qualify for this insurance. Please note, cov offered with a Medical Rider or Conditional Rate Up for coverage. All questions answered Yes, must be explained in detail ir Application.

SECTION 3

Medical Information

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the correspo
condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and all other
treatment, prognosis, and present course of treatment. **Please attach additional pages as necessary.** Azimuth reserves the right to

Family Member (use letters from Section 1)	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/C Care Provider Name(s Telephone Nu

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

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

CERTIFICATION: I (we) hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I (we) have read the questions c
and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date h
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 pre-ex
(we) intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the signer wa
acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind

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

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

Signature of Applicant, Guardian or Proxy

Signature of Spouse

COBERTURA ELITE TERM LIFE INSURAN

The Cobertura Elite Term Life Insurance is underwritten by Certain Underwriters at Lloyd's, London. It is distributed, managed and ac
Term Life Insurance is only available at the time of application for, and with the purchase of, The Cobertura Elite.

Note: The Primary Applicant purchasing Term Life Insurance must be age 55 and under. Any individual over age 55 or any individua
denied coverage.

SECTION 4.