

THE MERIDIAN SERIES APPLICATION



Going Your Way

The Meridian Series Insurance Plans 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, LLCsm (Azimuth).

Important Information

The Meridian Series offers two options: world-wide 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.

Directions for Completing the Application

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

- In Section 1, print or type your name and the names of all other familymembers 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 mailed, such as fulfillment kit, renewal forms, and any claims information.
- 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.
- U.S. Citizens: If you or any family member applying for coverage is located in the U.S. on the date of this application, the effective date of this insurance, if issued, will be the later of: (i) The effective date requested on the application; or (ii) The date the insured person departs the U.S.; or (iii) The date the application is accepted by Azimuth and an Evidence of Insurance issued.
- Non-U.S. Citizens: If you or any family member applying for coverage is located in the U.S. on the date of this application and do not plan to depart the U.S., 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 renewal.
- 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.

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

Meridian Series - Enhanced				Meridian Series - Basic	
Coverage Area	Deductibles		Dental Rider	Sports Rider	Express Delivery \$25.00 (US) \$35.00 (All Others)
Including US/Canada	□ \$ 250 □ \$ 500 □ \$ 1,000	\$2500 \$5,000 \$10,000	☐ Yes ☐ No	☐ Yes ☐ No	□ \$ 25 □ \$ 35
Excluding US/Canada	□ \$ 250 □ \$ 500 □ \$ 1,000	\$ 2500 \$ 5,000 \$ 10,000	☐ Yes ☐ No	☐ Yes ☐ No	□ \$ 25 □ \$ 35
Requested Effective Date:			_	Departure Date:	

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).

those family members applying for coverage under the beacon/Axis se	ries Group msur	ance Trust (An	iguilia).		
NAME Please print your name below	HEIGHT	WEIGHT	DATE OF BIRTH mo/day/yr.	COUNTRY OF CITIZENSHIP	PERSONAL IDENTIFICATION NUMBER (Passport, SS# OR DL#)
A. APPLICANT (Last, First, Middle) Sex: MALE FEMALE					
B. (Last, First, Middle) Sex: MALE FEMALE					
C. (Last, First, Middle) Sex: MALE FEMALE					
D. (Last, First, Middle) Sex: MALE FEMALE					
E. (Last, First, Middle) Sex: MALE FEMALE					
F. (Last, First, Middle) Sex: MALE FEMALE					
G. (Last, First, Middle) Sex: MALE FEMALE					
H. (Last, First, Middle) Sex: MALE FEMALE					
I. (Last, First, Middle) Sex: MALE FEMALE					
J. (Last, First, Middle) Sex: MALE FEMALE					

RESIDENCE ADDRESS				
Street Address:				
City: State/Postal Code:				
Country:	Phone:			
Email:				
☐ I Would you like to receive insurance documents electronically?(Y/N):				

SECTION 1 (Continued)

220111 (00111111111111111111111111111111				
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 ABOVE QUESTION, OR THE RESIDENCE ADDRESS IS NOT COMPLETED, AN AFFIDAVIT OF ELIGIBILITY MUST BE COMPLETED). MAIL FORWARDING ADDRESS				
Street Address:				
City:	State/Postal Code:			
Country:	Phone:			
Email:				
IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENTLY LOCATED IN FLORIDA?(Y/N) : ☐ Yes ☐ No				
THE ABOVE QUESTION IS FOR SURPLUS LINES TAX D	ETERMINATION 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 member by from Section	using let	tters		
1. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	☐ Yes	□ No			
2. Are you or any other applicant pregnant or have an adoption pending?	☐ Yes	□ No			
3. Are you or any other applicant currently disabled or unable to perform normal activities?	☐ Yes	□ No			
4. Do you or any other applicant participate in professional sports?	☐ Yes	□ 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 organtransplant (other than corneal)?	☐ Yes	□ 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?	☐ Yes	□ 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, LLC. For further assistance. Thank you for the opportunity 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?	☐ Yes	□ 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.	☐ Yes	□ No			
9. Have you or any other applicant ever been diagnosed with or treated for diabetes, hyperglycemia, hypoglycemia, or sugar in the blood orurine? If yes, please explain in section 3 of this application. You may be required to complete a diabetes questionnaire.	☐ Yes	□ No			
If any individual answered YES to any of the above three questions, he or she may not qualify for this insurance.					

Co. Name & Location :	Date(s) of	Cover :		
yes, please state the name and location of the insurance company, the	ealth or medical insurance plan during the last twelve (12) months? If e policy number or plan number, and the dates of coverage below: Policy/Plan :	☐ Yes	□ No	
29. Any other disease, medical problem, illness, injury or condition of	of any kind not listed above?	☐ Yes	□ No	
28. Eyes, ears, nose, mouth, throat or jaw, including, but not limited	to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐ Yes	□ No	
27. Digestive system, stomach, or intestines, including but not limite	d to: esophageal, regurgitation, gastritis, ulcers, colon, or rectum disorder?	☐ Yes	□ No	
26. Sexually transmitted disease (STD)?				
25. For female applicants, miscarriage, complicated pregnancy or de	livery, or infertility consultation, advice, diagnosis or treatment?	☐ Yes	□ No	
24. Reproductive systems, including but not limited to: prostate or el fallopian tubes, ovaries or uterus?	evated PSA level, vaginal bleeding, fibroids, nodules or breast cysts,	☐ Yes	□ No	
23. Kidney, urinary tract functions, kidney or bladder stones or infec	tions?	☐ Yes	□ No	
22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical or drug abuseor dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?				
21. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?				
20. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid, metabolic disorders, or obesity?				
19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or anyother back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis or inflammation?				
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?				
17. Congenital, genetic, hereditary or other birth condition or defect other chromosome disorder, physical disorder, deformity or defect?	☐ Yes	□ No		
16. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell dis	☐ Yes	□ No		
15. Blood, blood vessels, spleen, arteries, veins or disorders of the bl hepatitis,lymph glands, or high cholesterol?	☐ Yes	□ No		
14. Heart, cardiac, cardiovascular and/or circulatory, including, but rarteriosclerosis, elevated blood pressure, hypertension, hypotension, heartmurmur?	☐ Yes	□ No		
	tion or symptoms of, suffered from, sought consultation, examination, illness, medical problem, disorder, sickness or other problem a			
13. During the last five (5) years, have you or any other applicant had dependency, problem or abuse or any drug or alcohol related arrest?	d any indication, diagnosis or treatment of an alcohol or drug	☐ Yes	□ No	
12. During the last twenty-four (24) months, have you or any other a frequency in section 3 of this application.	pplicant used tobacco of any form? If yes, please indicate type and	☐ Yes	□ No	
11. During the last twelve (12) months, have you or any other application	ant experienced a weight change of 20 pounds or more?	☐ Yes	□ No	
10. During the last twelve (12) months, have you or any other application received any consultation, examination, testing or treatment (incluneryous condition?		☐ Yes	□ No	
For questions 10-30, below must be answered for the application answered "YES," please indentify the family member of this Application, and provide complete details of the medinumber of attending physician(s), diagnosis, all treatment details and Underwriters reserve the right to request additional treatment of the complete details of the median complete details of the	om Section ne, address	n 1 s,and telep		

For any question answered "YES" in Section 2, please identify each Family Member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address and telephone number of the attending physician(s), hospital(s), clinic(s) and allother health care providers involved, diagnosis, all treatment dates, type(s) of treat-ment, prognosis, and present course of treatment. Please attach additional pages asnecessary. Azimuth reserve the right to request 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/Hospital/Clinic/Health Care Provider Name(s), Address & Telephone Number	Date(s) of Treatment/Service

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, LLC. and/or Underwriters and my agent/broker involved in procurement of this application.

ACKNOWLEDGEMENT: I (we) understand and agree that: (i) the insurance agent, broker, website, or other producer, if any, involved with respect to the solicitation of this Application is acting solely as my legal agent or representative and is representing my (our) personal interest, and that such person has no authority to bind or speak for, and is not acting as the legal agent or representative of Azimuth or Underwriters, (ii) marketing brochures and Evidence(s) of Insurance wordings are available to us prior to application upon request, (iii) any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the three (3) years prior to the effective date of coverage and time of this insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date herein (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance for a period(s) up to twelve (12), twenty-four (24), or the duration of this insurance, and thereafter, certain benefits and/or all benefits will be reduced as stated in the Evidence of Insurance (available upon request prior to application), and/or the Schedule of Benefits as shown on the brochure and application, (iv) the subjects of insurance applied for are not intended or considered by the applicant(s), Azimuth or Underwriters to be resident, located, or to be performed in any particular state of the United States, and (v) Underwriters, as carrier and Underwriters of the plan, is solely liable for the coverage's and benefits to be provided under this insurance, Azimuth acts solely as a agent/representative for Underwriters and has no independent liability under the Master Policy or any Evidence(s) of Insurance issued by the Master Policy.

CERTIFICATION: I (we) hereby certify, represent and warrant to Azimuth and Underwriters that: (i) I (we) have read the questions contained in this Application or that the questions have been read to me (us), and I (we) understand them, (ii) my (our) responses to the questions are true, accurate and complete in all respects as of the date hereof, and that I (we) will supplement such responses prior to the requested 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 and other information disclosed herein,

Signature of Applicant Or

Guardian X

I (we) have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing which I (we) foresee may require treatment in the future or for which I (we) intend to claim under this insurance, and (iv) if this Application signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant.

SATISFACTION GUARANTY/REVIEW PERIOD: It is understood I (we) will have 7 days from the effective date to review the Evidence of Insurance and all benefits, terms, conditions, limitations and exclusions of coverage. If not completely satisfied, I (we) may cancel this insurance by written request retroactive to the effective date and receive a full refund of premium.

SUBSCRIPTION: I (we) hereby apply for membership in the Beacon/ Axis Series Group Insurance Trust (Anguilla), and for the insurance provided to Participating Member(s) by certain Underwriters at Lloyd's. I (we) understand and agree that (i) no coverage will be effective until this Application has been duly accepted in writing by Azimuth Risk Solutions, LLC. (Azimuth), (ii) no modifications or waiver relating to this Application or the coverage applied for will be binding upon Azimuth or Underwriters unless approved in writing by an officer of Azimuth or Underwriters, (iii) Azimuth and Underwriters rely on the accuracy and completeness of the information provided herein, (iv) any misrepresentation or omission contained herein will void this insurance, and any and all claims and benefits there under will be forfeited and waived, (v) by submission of this Application and/or any future claim for benefits I (we) purposefully initiate and take advantage of the privilege of conducting business with Azimuth Risk Solutions, LLC. a Indiana based company, and registered agent/representative of Certain Underwriters at Lloyd's, London, and invoke the benefits and protections of its laws, and (vi) the contract of insurance represented by the Master Policy and evidenced by the Evidence of Insurance shall be deemed issued and made in Indianapolis, Indiana, I (we) understand that Certain Underwriters at Lloyd's, 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 understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of 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 and bind the Applicant.

Date (Mo./Day/Yr.)

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. 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.

	(1) MEDICAL PREMIUM	(2) OPTIONAL DENTAL RIDER	(3) OPTIONAL SPORTS RIDER	(4) TOTAL
A. Applicant	\$	\$	\$	\$
В.	\$	\$	\$	\$
C.	\$	\$	\$	\$
D.	\$	\$	\$	\$
E.	\$	\$	\$	\$
F.	\$	\$	\$	\$
G.	\$	\$	\$	\$
Н.	\$	\$	\$	\$
I.	\$	\$	\$	\$
J.	\$	\$	\$	\$

First Payment Total Due

	*Modal factors:	☐ ANNUAL = 1.00	SEMI-ANNUAL = 0.55	☐ QUARTERLY = 0.28	☐ MONTHLY = .20	
	(Please sele	ct a payment mode)				
	\$	X	= \$	+ Optional express mailing fee (\$25	5 in US, \$35 outside US): \$	
l	(Subtotal A)	*Modal Factor	Total			
	Total First	Payment Due: \$				

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

		(-, 1	J Paganara and and	
*Modal factors:	☐ ANNUAL = 1.00	☐ SEMI-ANNUAL = 0.55	☐ QUARTERLY = 0.28	☐ MONTHLY = .10	
(Please selec	ct a payment mode)				
\$	X	= \$			
(Subtotal A)	*Modal Factor	Total Premium du	e 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					

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.

Section 6

Method of Payment

☐ Check(annual only) ☐ Money o	order(annual only)			
authorize Azimuth to debit my Visa card, MasterCard, America semi-annual payment modes, I (we) hereby request and authoriz Azimuth. This authorization will remain in effect for up to 12 m	s and money orders payable to Azimuth Risk Solutions, LLC. (Azimuth). If paying by credit card, I (we) in Express card, or Discover card account for the total amount due. If I have selected monthly, quarterly, or ze Azimuth to debit my credit card account for the proper installment payment due on the due date set forth by nonths or as long as I (we) continue to renew my (our) coverage, or until coverage is revoked in writing. independent of the credit card company. I understand that coverage will not be effective if the credit card company.			
Name as it appears on card :	Billing Address :			
Credit Card Number :	Expiration Date :			
Daytime Phone Number :	Authorized Signature :			
(we) have personally completed this Application. I (we) represe (we) understand Azimuth Risk Solutions, LLC. relies on the information of the Underwriting and Eligibility requirements of the plant claims will be forfeited. I understand that this insurance contains set forth in the Policy. I understand that I may request a complet that if this Application is not accepted, the sole obligation of Az Lloyd's, London as underwriter of the plan, is solely liable for the non-admitted insurer in all states of the United States except Illistate guaranty fund. I (we) understand that the insurance Agent undersigned authorizes any doctor, medical practitioner, hospita	Group Insurance Trust (Anguilla) and for the insurance provided to Participating Members by Lloyd's, London. I and warrant that the answers and statements on this Application are true, complete and correctly recorded. I formation provided on this Application, including any attachments, to determine whether or not the Applicant(s). I (we) understand that any misrepresentation or omission contained herein will void my (our) insurance and all is Pre-existing condition exclusions, Pre-certification penalties, and other restrictions, exclusions and limitations te copy of the Master Policy at any time and that Azimuth Risk Solution agrees to provide it to me. I understand muth Risk Solutions is to return to me any premium(s) paid. I (we) understand that Certain Underwriters at the coverage and benefits provided under this insurance. I (we) understand that Lloyd's operates as an approved, inois and Kentucky, where they are admitted. As such, claims under this insurance may not be made against any or Broker, if any, assisting me (us) with this Application is a representative of me (us) the Applicant. The al, clinic, health facility, pharmacy, government agency, insurance agency, insurance company, group entity having information as to the care, advice, treatment, diagnosis, or physical or mental condition of any nation to Azimuth Risk Solutions, LLC.			
X Signature of Applicant, Guardian or Proxy Date (Mo./Day/Yr.) X Signature of Spouse Date (Mo./Day/Yr.)				
Section 7				
Insurance Agent/Broker (AGENT USE ONLY)	Agimuth Agent News A Deb Device			
	Azimuth Agent Name : Rob Paris			
Company Name : Cornerstone Ministry Risk Management				

Insurance Agent/Broker (AGENT USE ONLY)					
Azimuth Agent Number : 0c42d0d0		Azimuth Agent Name	Rob Paris		
Company Name : Cornerstone Ministry	Risk Management				
Company Address : 8120 Sheridan Blvd	Company Address : 8120 Sheridan Blvd.,Ste. C-219				
City : Westminster		State, Postal Code : Colorado, 80003			
Phone : 719-244-9282	Fax : 719-358	3-9228	Country : United States		
Email : mgannon@ministryriskmanagement.com					
Website : http://www.mrm-ins.com/					
Agent/Broker Signature :					

