THE MERIDIAN SERIES

APPLICATION



www.azimuthrisk.com





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 1 N Pennsylvania Street, Ste 200, Indianapolis, IN 46204 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 preauthorization 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

☐ Meridian Series- Enhanced							☐ Meridian Series- Essential			
Coverage Area	Deductibles				Dental Rider		Optional Extream Sports Rider			Express Delivery
Including US/Canada	☐ \$ 250 ☐ \$ 2500 ☐ \$ 500 ☐ \$ 5,000 ☐ \$ 1,000 ☐ \$ 10,000			☐ Yes		☐ Yes		□ \$ 25 □ \$ 35		
Excluding US/Canada	☐ \$ 250 ☐ \$ 2500 ☐ \$ 10,000 ☐ \$ 10,000				☐ Yes		☐ Yes ☐ No			□ \$ 25 □ \$ 35
Requested Effective Date	:						Departure Date:			
nose family members apply						ranc	e Trust (Ang	uilla).		ONLY include the names of
NAME Please print your na	ame below	Sex	Heigh	ıt	Weight		ite of Birth lo/Day/Yr.	Country Citizens		Personal Identification Number (Passport, SS# or DL#)
A. Applicant(Last, First, I	Middle)	☐ Male ☐ Female								
B. (Last, First, Middle)		☐ Male ☐ Female								
C. (Last, First, Middle)		☐ Male								
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							
RESIDENCE ADDRESS								
STREET ADDRESS:			CITY, STATE, F	POSTAL CODE:				
COUNTRY:	OUNTRY: TELEPHONE:			☐ I would like to receive my insurance documents electronically (please check the box to receive your documents by email)				
IS YOUR EXPECTED LENGTH OF RESIDENCE OUTSIDE THE US AT LEAST 6 OF THE NEXT 12 MONTHS? (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:	CITY, STATE, COUNTRY:							
EMAIL: TELEPHONE:								
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								

☐ Male

J. (Last, First, Middle)

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				
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 🗌				
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 organ transplant (other than corneal)?	e of Yes 🗌 No 🗌				
6. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Description (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV) or 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. It Solutions, For further assistance. Thank you for the opportunity to serve you.	Please contact Azimuth Risk				
7. If a non-US citizen, have you or any other applicant resided continuously inside the US 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 past (5) years? If yes, please explain in section 3 of this application.	g the Yes 🗌 No 🗌				
9. Have you or any other applicant ever been diagnosed with or treated for diabetes, hyperglycemia, hypoglycemia, or sugblood or urine? If yes, please explain in section 3 of this application. You may be required to complete a diabetes question					
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, h mental, physical or nervous condition?	ealth, Yes □ No □				
11. During the last twelve (12) months, have you or any other applicant experienced a weight change of 20 pounds or more	e? Yes 🗌 No 🗀				
12. During the last twenty-four (24) months, have you or any other applicant used tobacco of any form? If yes, please indicand frequency in section 3 of this application.	ate type Yes No				
13. During the last five (5) years, have you or any other applicant had any indication, diagnosis or treatment of an alcohol dependency, problem or abuse or any drug or alcohol related arrest?	or drug Yes ☐ No ☐				
Have you or any other applicant ever experienced manifestation or symptoms of, suffered from, sought consultation, example been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness or other problem arising from, in following:					
14. Heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, and chest pain, arteriosclerosis, elevated blood pressure, hypertension, hypotension, swelling of feet/ankles, thrombosis, phlei 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, lymph glands, or high cholesterol?	, Yes □ No □				
16. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any l	kind? Yes ☐ 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?	Yes ☐ No ☐				
18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebra ischemic attacks?					
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?	Yes ☐ No ☐				
20. Liver, Pancreas, Gall Bladder or endocrine disorders including, but not limited to: pituitary, thyroid, metabolic disorders obesity?	s, or Yes □ No □				
21. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, basthma, pleurisy pneumonia?	ronchial Yes ☐ No ☐				
22. Mental and nervous system disorders including, but not limited to: psychosis, mental or behavioral disorders, chemical abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or esteeping disorders?	~ v — N —				
23. Kidney, urinary tract functions, kidney or bladder stones or infections?	Yes 🗌 No 🗌				
24. Reproductive systems, including but not limited to: prostate or elevated PSA level, vaginal bleeding, fibroids, nodules or cysts, fallopian tubes, ovaries or uterus?	or breast Yes 🗌 No 🗍				
25. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, diagnosis or treatment?	Yes ☐ No ☐				
26. Sexually transmitted disease (STD)?	Yes 🗌 No 🗌				
27. Digestive system, stomach, or intestines, including but not limited to: esophageal, regurgitation, gastritis, ulcers, colon rectum disorder?	, or Yes 🗌 No 🗍				
28. Eyes, ears, nose, mouth, throat or jaw, including, but not limited to: cataracts, glaucoma, nasal septum deviation, chrosinusitis, or TMJ?	nic Yes □ No □				
29. Any other disease, medical problem, illness, injury or condition of any kind not listed above?	Yes ☐ No ☐				
30. Have you or any other applicant been covered under any other health or medical insurance plan during the last twelve months? If yes, please state the name and location of the insurance company, the policy number or plan number, and the coverage below:					
Co. Name & Location: Policy/Plan # :	Date(s) of Cover:				

Medical Information

Signature of Spouse

1),and provide complete det clinic(s) and all other health	ails of the medical condition at issue, including the r care providers involved, diagnosis, all treatment dat	mber for whom the answer applies (using the correspon name, address and telephone number of the attending pless, type(s) of treatment, prognosis, and present course additional medical information prior to acceptance of thi	physician(s), hospital(s), of treatment. Please
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 DELEASE: L'oug	horoby authorize any doctor, practitioner of the	he healing arts, hespital, clinic, health related facility	ity pharmacy government
agency, insurance agency, advice, treatment, diagnosi	insurance company, group policyholder, emp	he healing arts, hospital, clinic, health related facil loyee or benefit plan administrator having inform ndition, or financial and employment status, to procurement of this application.	ation as to my (our) care,
the solicitation of this Appliperson has no authority to be and Evidence(s) of Insurand medical, mental or nervous the three (3) years prior to consequences related there effective date herein (a "preinsurance for a period(s) upreduced as stated in the Evand application, (iv) the sul located, or to be performed the coverage's and benefits	cation is acting solely as my legal agent or re- poind or speak for, and is not acting as the legal ce wordings are available to us prior to applicat condition, disorder or ailment that, with reasonathe effective date of coverage and time of this eto or arising there from, whether or not previou- existing condition"), and that all charges and/or to twelve (12), twenty-four (24), or the duration idence of Insurance (available upon request priopiects of insurance applied for are not intended in any particular state of the United States, and	nce agent, broker, website, or other producer, if an expresentative and is representing my (our) person agent or representative of Azimuth or Underwriter ion upon request, (iii) any injury, illness, sickness, able medical certainty, existed at the time of applications insurance, including any subsequent, chronic or usely manifested or symptomatic, diagnosed, treate or claims for pre-existing conditions will be excluded in of this insurance, and thereafter, certain benefits do roconsidered by the applicant(s), Azimuth or U d (v) Underwriters, as carrier and Underwriters of cts solely as a agent/representative for Underwrite the Master Policy.	nal interest, and that such is, (ii) marketing brochures disease, or other physical, ation or at any time during recurring complications or d, or disclosed prior to the d from coverage under this is and/or all benefits will be as shown on the brochure inderwriters to be resident, the plan, is solely liable for
Application or that the quesicomplete in all respects as change or addition thereto, not been diagnosed with, so pre-existing which I (we) for signed as guardian or prox	tions have been read to me (us), and I (we) und of the date hereof, and that I (we) will supplem (iii) I am (we are) currently in good health and, ought consultation or been treated for, and hav resee may require treatment in the future or for try of the applicant, the signer warrants their au	n and Underwriters that: (i) I (we) have read the of derstand them, (ii) my (our) responses to the question and the responses prior to the requested effective except for the conditions and other information disverse not experienced manifestation or symptoms of a which I (we) intend to claim under this insurance uthority and capacity to so act and to bind the apthe authority of the signer to so act and bind the apthe	ons are true, accurate and we date in the event of any sclosed herein, I (we) have and do not suffer from any and (iv) if this Application oplicant. By acceptance of
and all benefits, terms, cond		will have 7 days from the effective date to review if not completely satisfied, I (we) may cancel this in	
Participating Member(s) by been duly accepted in writin will be binding upon Azimut the accuracy and completer any and all claims and bene purposefully initiate and tak agent/representative of Cer represented by the Master understand that Certain Un(we) understand that Lloyd' are admitted. As such, clai agent/broker, if any, assistit authorizes his/her capacity	certain Underwriters at Lloyd's. I (we) understage by Azimuth Risk Solutions (Azimuth), (ii) nor in hor Underwriters unless approved in writing by hess of the information provided herein, (iv) any effits there under will be forfeited and waived, (ve advantage of the privilege of conducting busitain Underwriters at Lloyd's, London, and invol Policy and evidenced by the Evidence of Insderwriters at Lloyd's, as underwriter of the plan, so operates as an approved, non-admitted insurings under this insurance may not be made as any with this Application is a representative of the solution of the Asimutha of the surface of the solution of the Asimutha of the surface of the solution of the Asimutha of the surface of the solution of the Asimutha of the surface of the su	s Series Group Insurance Trust (Anguilla), and for and and agree that (i) no coverage will be effective modifications or waiver relating to this Application of an officer of Azimuth or Underwriters, (iii) Azimuth or Underwriters, (iii) Azimuth or instepresentation or omission contained herein or or by by submission of this Application and/or any futuiness with Azimuth Risk Solutions a Indiana based where the benefits and protections of its laws, and (visurance shall be deemed issued and made in Inc. is solely liable for the coverage and benefits proviner in all states of the United States except Illinois gainst any state guaranty fund. I understand and he Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacities the authority of the signer to so act and bind the	e until this Application has or the coverage applied for h and Underwriters rely on i'll void this insurance, and tre claim for benefits I (we) d company, and registered) the contract of insurance dianapolis, Indiana, I (we) ded under this insurance. I and Kentucky where they agree that the insurance Applicant, the undersigned by to so act. By acceptance
Signature of Applicant, Go	uardian or Proxy		

Date (Mo./Day/Yr.)

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. (1) MEDICAL (3) OPTIONAL EXTREAM (2) OPTIONAL APPLICANT (4) TOTAL DENTAL RIDER SPORTS RIDER PREMIUM В. C. E. F. G. OPTIONAL MATERNITY RIDER (APPLIES ONLY TO MERIDIAN ESSENTIAL PLAN (IF Applicable) OPTION). PLEASE CHECK HERE IF PURCHASING THE MATERNITY RIDER $\ \square$ Please add all totals listed in column number 4 and list total here (Subtotal A) First Payment Total Due Modal Factors: ☐ ANNUAL = 1.00 ☐ SEMI-ANNUAL = 0.55 ☐ QUARTERLY = 0.28 ☐ MONTHLY = .20 (Please select a payment mode) \square In US \square Out US Optional express mailing fee *Model Factor (Subtotal A) Total): Total First Payment Due: \$

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

Modal Factors:	□ A	NNUAL = 1.00	☐ SEMI-ANNUAL = 0.	.55 QUAR	TERLY = 0.28	☐ MONTHLY = .10
(Please select a page	yment m	node)				
(Subtotal A)	X	*Model Factor	- =	Total Premi	um due for all rem	naining 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

\Box Check (annual only) \Box Money Order (annual only) \Box Visa	a Card ☐ Master Card ☐ American	n Express ☐ Card Discover Card
All payments must be made in U.S. dollars. Please make checks and mo credit card, I (we) authorize Azimuth to debit my Visa card, MasterCard, & If I have selected monthly, quarterly, or semi-annual payment modes, I (w for the proper installment payment due on the due date set forth by Azim I (we) continue to renew my (our) coverage, or until coverage is revoked i acceptance by the credit card company. I understand that coverage will n American Express cards, the CSC is a 4 digit number printed on the front on the signature panel on the back of the card immediately following the a	American Express card, or Discover we) hereby request and authorize Az uth. This authorization will remain in in writing. Coverage purchased by count to be effective if the credit card com above the account number. On all com	card account for the total amount due. imuth to debit my credit card account effect for up to 12 months or as long as redit card is subject to validation and pany denies the charge. Note: On other cards, it is a 3 digit value printed
Name as it appears on Card:	Billing Address:	
Credit Card Number:	Expiration Date:	Card Security Code(CSC):
Daytime Phone Number:	Authorized Signature:	
I (we) hereby apply for membership in the Beacon/Axis Series Group Inst Members by Lloyd's, London. I (we) have personally completed this Applithis Application are true, complete and correctly recorded. I (we) understa Application, including any attachments, to determine whether or not the A I (we) understand that any misrepresentation or omission contained here that this insurance contains Preexisting condition exclusions, Pre-certificathe Policy. I understand that I may request a complete copy of the Master me. I understand that if this Application is not accepted, the sole obligation understand that Certain Underwriters at Lloyd's, London as underwriter or insurance. I (we) understand that Lloyd's operates as an approved, non-askentucky, where they are admitted. As such, claims under this insurance the insurance Agent or Broker, if any, assisting me (us) with this Applicationathorizes any doctor, medical practitioner, hospital, clinic, health facility, group policyholder, or insurance or benefit administrator or any other entiphysical or mental condition of any Family Member listed on this Applicational conditions.	ication. I (we) represent and warrant and Azimuth Risk Solutions, LLC. relepplicant(s) meets the Underwriting a in will void my (our) insurance and attion penalties, and other restrictions. Policy at any time and that Azimuth n of Azimuth Risk Solutions is to retif the plan, is solely liable for the covadmitted insurer in all states of the U may not be made against any state on is a representative of me (us) the pharmacy, government agency, insty having information as tothe care,	that the answers and statements on lies on the information provided on this and Eligibility requirements of the plan. Il claims will be forfeited. I understand s, exclusions and limitations set forth in I Risk Solution agrees to provide it to urn to me any premium(s) paid. I (we) erage and benefits provided under this nited States except Illinois and guaranty fund. I (we) understand that a Applicant. The undersigned urance agency, insurance company, advice, treatment, diagnosis, or
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: 9722c3fb	Azimuth Agent Name: Sami Qubty	
Company Name: Qubty Financial Group		
Company Address: 7680 Universal Blvd. #405	City, State, Postal Code: Orlando F	Florida, 32819
Phone: 407-370-3030	Fax: 407-370-2040	Country: United States
Website: www.QubtyFinancialGroup.com	Email: squbty@qubtyfinancialgrou	p.com
Agent/Broker Signature:		



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