

MERIDIAN CLEAR BROCHURE



Going Your Way





Does International Medical Insurance Make Sense for Me?

If it matters to you to have flexibility and security in where, when and how you receive your health care services, the Meridian Clear Plan can offer you authentic peace of mind. This peace comes from the knowledge that you will have the ability to choose access to the best medical care available, either in your country of residence, or anywhere you may elect to go for its delivery in the world. Meridian Clear provides you with a private medical care alternative that allows you to choose from any provider, no matter where they practice in the world and know that you have the ability to positively impact the quality of your medical services. With the creation of Meridian Clear, Azimuth Risk Solutions, LLC has created a plan to make what is important to you important to us.

Who Is Eligible for Meridian Clear?

Meridian Clear is a true industry innovation which is designed to provide coverage for clients who may not have qualified for other international medical plans, either because of suboptimal health conditions, or have an immediate need for coverage. Clients who qualify medically and are more than 14 days old and under the age of 65 who either live outside of the United States, or who would not qualify for a US domestic health insurance plan as a result of their citizenship status may apply for the plan. Once accepted, you would be able to renew indefinitely with no medical questions at your renewal period (subject to the terms of the Evidence of Insurance). Those clients who qualify medically and are accepted on the plan after the age of 65 would be able to renew their plan up to their 75th birthday. If you are a US citizen, you must leave the US within 30 days of your effective date of insurance and within 30 days of your renewal date if you are in the US at that time. You will receive notice of your renewal approximately 60 days in advance of your date of renewal.

Who Insures This Plan?

The preeminent name in international insurance is Lloyd's, London. This largest, oldest and most respected insurance market is the insurer on all Azimuth Risk Solutions, LLC. plans. You will have the security of knowing that you are working with an insurer who has paid every eligible claim for more than 320 years. Lloyd's is 'A' rated by AM Best and Standard & Poor's for their superior ability to pay claims.

Who Is Azimuth Risk Solutions?

Headquartered in Indianapolis, Indiana, Azimuth Risk Solutions, LLC (Azimuth) is a service-first organization formed by professionals with nearly 30 years in the international insurance industry to provide simply the finest in product offering, administration and support after the sale of international health, travel and life insurance products. If it's important to you to do business with an organization that is committed both to service excellence and to ethical conduct as well as philanthropic pursuits, Azimuth is the choice to meet your requirements. Azimuth is a Coverholder for our insurer, certain Underwriters at Lloyd's, London and the Administrator for the Meridian Clear Plan.

The Meridian Clear Difference

The Meridian Clear Plan provides coverage to a much broader segment of the international medical insurance market than has been available in the past. Azimuth does this by providing predictable benefit amounts for unforeseeable illnesses and injuries at an affordable premium point. There are different choices available to you in the international medical insurance market; the key is selecting an insurance provider which you can be confident will be available to you at your time of need, which understands the culture of international living and has the security to weather the financial environment in the world as it is today. By choosing Meridian Clear, you can be certain that you have made the correct selection on all counts.

The Meridian Clear Speed Underwriting

The Meridian Clear Plan is uniquely suited for instant issue. By completing the questions on the application and submitting your application to Azimuth by fax, mail or email, we will review and respond with the results of the review the following business day after receipt. Alternatively, you may apply via the internet and if approved, obtain instant verification of acceptance on the plan. Once you are confirmed on the plan, you will receive verification of coverage via email if you provide the information, followed by a complete fulfillment kit containing your Evidence of Insurance, identification card(s), claim form, welcome letter and receipt for the transaction. If your application is declined, your premium will be refunded in total. Your full satisfaction is our goal and after receiving your fulfillment you have the opportunity for a 7 day review of the plan. If for any reason you are not completely satisfied you may cancel your plan via written notice to Azimuth Risk Solutions, LLC and receive a full refund of your paid premium amount. After this 7 day period has elapsed, you may cancel at any time by providing 60 days written notice to Azimuth Risk Solutions, LLC. Your unearned premium amount will be returned, less a Short Rate Cancellation Fee which is indicated on the Lloyd's, London jacket which contains your Evidence of Insurance.

International Client Assistance

If it matters to you to know that someone is always by your side while traveling in a distant land, the Meridian Series can ease your mind while you are away from the familiar surroundings of home. For no extra charge, each Meridian Series Plan includes the following key services to help you when you are in the greatest need:

- **24/7 Live Call Center** - never worry about getting lost in voicemail while you are many time zones away. A caring, helpful voice on the other end of the phone is always ready to help
 - **Lost Baggage Tracking** - if you've ever had to chase down your airline baggage department to find out where your luggage may have gone, you will appreciate our ability to do so on your behalf. Enjoy your travel without having to make multiple phone calls to get updates on your baggage delivery
 - **Medical Referrals** - need a doctor or the nearest hospital? One free call gets you the information you need
 - **Travel Advisories** - get in the know, before you go; call us to learn areas to avoid, travel delays, weather alerts and more
 - **Crisis Cash Advance** - we'll help you get to your money so you can stay on the go
- Much, much, more

THE MERIDIANIES CLEAR SCHEDULE OF BENEFITS	
Maximum Limit	\$2,000,000 Maximum Limit
Deductibles	\$500; \$1,000; \$2,500; \$5,000; \$10,000 per Participating Member per Coverage Period
Coverage Area	Area 1- Worldwide Including US & Canada Area 2- Worldwide Excluding US & Canada
Coinsurance – Claims incurred inside US or Canada	After the Deductible the Plan will pay 80% of the next \$5,000 of Eligible Medical Expenses, then 100% to the Maximum Limit. Coinsurance will be waived if Eligible Medical Expenses are incurred within the Preferred Provider Organization Network
Coinsurance – Claims incurred outside US or Canada	After the Deductible the Plan will pay 100% of Eligible Medical Expenses to the Maximum Limit
Pre-notification Penalty	50% Eligible Medical Expenses
Pre-existing Condition	\$5,000 Sub-Limit per Coverage Period, \$50,000 Maximum Sub-Limit, After 728 of continuous coverage
INPATIENT BENEFITS ONLY	
Hospital Room and Board – Coverage Area 1	\$400 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes ICU days)
Hospital Room and Board – Coverage Area 2	\$300 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes ICU days)
Intensive Care Unit – Coverage Area 1	\$1,000 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes Non-ICU days)
Intensive Care Unit – Coverage Area 2	\$800 Sub-Limit per day, 240 day Maximum per Hospitalization (Includes Non-ICU days)
INPATIENT/OUTPATIENT BENEFITS	
Chemotherapy and Radiation	Usual, Reasonable, and Customary
Surgical Consultant	\$350 Sub-Limit per consultation prior to Surgery
Surgeon/Surgery	Usual, Reasonable, and Customary
Assistant Surgeon	20% of Surgeon benefit
Anesthesiologist	20% of Surgeon benefit
Diagnostic Laboratory	\$250 per exam (Includes all procedures carried out on one specimen)
Diagnostic Radiology	\$250 per exam (Includes X-Rays, Ultrasounds, Sonograms and Diagnostic Mammograms)
Diagnostic MRI, Scans and Scopes	\$500 Sub-Limit per exam, (Includes MRI, CAT Scans, PET Scans, Echocardiography, Endoscopy, Gastroscopy, Colonoscopy and Cystoscopy)
Physician	\$70 Sub-Limit per visit, 15 visits per Coverage Period
Physician Specialist	\$70 Sub-Limit per visit, 15 visits per Coverage Period
Physical Therapist	\$50 Sub-Limit per visit, 15 visits per Coverage Period
Local Ambulance	\$1,500 Sub-Limit per Coverage Period when Illness or Injury results in Hospitalization
OUTPATIENT BENEFITS ONLY	
Wellness - Adult	\$250 Sub-Limit per Coverage Period for Participating Members age 30 and over, Not subject to Deductible or Coinsurance, After 728 of continuous coverage
Wellness - Dependent Child	\$150 Sub-Limit per Coverage Period for Participating Members age 18 and under, Not subject to Deductible or Coinsurance, After 364 days of Continuous Coverage
Mental & Nervous Disorders	\$50 Sub-Limit per visit, 15 visits per Coverage Period for Outpatient Treatment, After 364 days of Continuous Coverage
Chiropractor	\$50 Sub-Limit per visit, 15 visits per Coverage Period, Must be prescribed by a Licensed Medical Physician, After 364 days of Continuous Coverage
EMERGENCY BENEFITS	
Emergency Room - Illness/Accident	Usual, Reasonable, and Customary, Subject to additional \$250 Deductible if Illness or Injury does not result in Hospitalization
Emergency Medical Evacuation	\$30,000 Maximum Sub-Limit
Emergency Reunion	Reimbursement up to \$7,500 for Expenses related to the Emergency Reunion of a relative or friend resulting from an Emergency Medical Evacuation of a Participating Member
MATERNITY BENEFITS	
Maternity - Normal or Complicated Delivery	\$10,000 Sub-Limit per Coverage Period, \$50,000 Maximum Sub-Limit, After 728 day of Continuous Coverage
Newborn Care	Included as part of Maternity benefit for the first 31 days of life
Midwife Services	\$350 Sub-Limit per covered Pregnancy
OTHER BENEFITS	
Human Organ/ Tissue Transplant	\$250,000 Sub-Limit per Covered Transplants
Return of Mortal Remains	Reimbursement up to \$30,000 for the return of a Participating Members Mortal Remains to his/her Home Country, Not subject to Deductible or Coinsurance
Prescription Drug Coverage	Reimbursement Only. Inpatient drugs are Usual, Reasonable and Customary. Prescription drugs are Subject to 20% Coinsurance in the US, Maintenance drugs are not covered
Durable Medical Equipment	Usual, Reasonable and Customary charges, Limited to a standard Wheelchair and/or Hospital Bed

*This is only a consolidated and summary description of some of the current Azimuth Risk Solutions benefits, conditions, limitation and exclusions. An Evidence of Insurance containing the terms, conditions and exclusions will be included in the fulfillment kit. Azimuth Risk Solutions reserves the right to issue the most current Evidence of Insurance for this plan in the event this application and / or brochure has expired, is modified, or is replaced with a newer version. A complete copy of the Master Policy is available at all times upon request.

Key Meridian Clear Benefits

Emergency Medical Evacuation

In the event you suffer a life threatening injury or illness, Meridian Clear provides benefits that are prepared to respond in a time of crisis. Emergency medical evacuation provides transportation to the nearest facility that is equipped to properly care for your condition. This does not necessarily mean a return to your home country or any specific country or territory, as the condition may demand treatment in a timely fashion which would not be the case if it was necessary for you to be repatriated. All emergency medical evacuations must be precertified and coordinated by Azimuth Risk Solutions, LLC to be eligible for coverage.

Emergency Reunion

We know it's important not to feel alone at a time of crisis, so Meridian Clear provides coverage to transport an immediate family member or friend to your bedside in the event you are evacuated. Meridian Clear will pay for round trip air or ground travel as well as lodging and meals for up to 15 days so that you will have companionship during your recovery.

Family Friendly Rates

International living can be financially challenging for a family and Meridian Clear helps make insurance affordable, thanks to our First Two Free feature. Families enjoy the benefit of having the first two children under age 10 covered at no extra charge if their parents are insured on the plan!

Optional Dental Rider

Azimuth wants to make you smile and the optional dental rider can help keep that smile looking great. By selecting this optional benefit plan, you can protect yourself from high dental costs with dental benefits that increase over a 3 year time horizon.

Optional Term Life and Accidental Death & Dismemberment (AD&D) Rider

If you reside outside of the US, you may have access to this valuable and easily added benefit. So long as you are accepted on your chosen version of the Meridian Basic or Enhanced plan, you would be able to add up to a total of \$100,000 of term life and AD&D to your plan with no additional medical questions. This powerful benefit allows you to have additional security for anyone who would suffer financially in the event of your passing.

Optional Term Life (including AD&D) If you reside outside of the US, you may have access to this valuable and easily added benefit. So long as you are accepted on the Meridian Clear Plan, you are eligible to add up to a total of \$100,000 in Term Life (including AD&D) to your plan with no additional medical questions. This powerful benefit allows you to have additional security for anyone who would suffer financially in the event of a tragic loss.

Preferred Provider Network

Taking advantage of Azimuth's broad selection of quality US preferred providers benefits you by allowing cost advantaged access to US medical care and the significant ease of finding a qualified health care provider virtually anywhere in the US. For providers outside the US, you may access care anywhere of your choosing, or simply contact Azimuth for a suggested referral.

What If I have a Claim?

The claim process is quite simple. In the event that you have a claim for eligible expenses you have already incurred, simply complete our Claim Form, which is included in your plan fulfillment and available online and return to Azimuth with your original receipts and your eligible expenses will be promptly refunded. As with every aspect of Azimuth's operations, if you have any difficulty, simply contact Azimuth and we will gladly help you with completing the process. In the event that you have a large or ongoing claim your pre-certification through Azimuth will in many cases allow us to arrange for your care and payment directly to your healthcare provider.

Pre-existing Conditions

If you have a medical condition which has occurred in the past or is ongoing, that condition must be disclosed on the application for underwriters' review. If you are accepted for the Meridian Clear Plan your existing condition will have a waiting period of 24 months before any coverage is available. After 24 months of continuous coverage, the existing condition will be limited to \$5,000 in any one Coverage Period and a plan maximum of \$50,000. The Meridian Clear Plan provides no coverage for prescription drugs to treat pre-existing conditions at any time.

Note: Coverage and/or benefits for these Illnesses or Surgeries (or for similar or different Illnesses or Surgeries) may be separately or further limited and/or excluded under the Pre-existing Conditions exclusion and definition.

180 Day Special Conditions Exclusion

In the first 180 days of coverage, charges are not covered which are related to treatment of any of the following: any condition of the breast, prostate, the reproductive system, tonsils, adenoids, hemorrhoids, hernia, gallstones, kidney stones, glaucoma, cataracts, disk disease, all types of cysts, and any disorder or disease of the skin.

Pre-certification

In order to receive complete benefits, hospital admissions, trip interruptions, repatriation of mortal remains, emergency reunions, emergency medical evacuations, any eligible inpatient or outpatient procedure as indicated in the Evidence of Insurance, must be pre-certified by contacting Azimuth Risk Solutions through the contact information indicated on the member's insurance card prior to receiving service. In the case of emergency hospital admission, Azimuth must be contacted within the first 48 hours of admission or as soon as possible. Pre-certification is not a guarantee of coverage.

The ARS Client Center

The ARS Client Center is a tremendous online resource which allows you to access information about your insurance on a round the clock basis. Whether you need to print a replacement identification card, to find a nearby doctor, check on a claim or much more, you can do so from any computer in the world. Azimuth recognizes that there are times that nothing substitutes for a caring human being. That is why the service first corporate culture is embodied in every phone call and every contact Azimuth makes with our valued clients. Azimuth stands ready to assist with any plan question or to help with these valuable services:

Meridian Clear Exclusions and Limitations*

While the Meridian Series provides the most thorough and expansive coverage available in the international market today, it is important to recognize that there are some conditions and circumstances where your plan would not provide coverage. Please take note of pre-existing condition criteria and information on what the Meridian Clear Plan would not cover:

- Investigational, experimental or research procedures
- Charges for cosmetic surgery or weight modification
- Treatment for sleep disorders/hair growth/exercise programs
- Contraceptive medication or treatment
- Drug and alcohol abuse treatment
- Organ transplants not specifically listed
- Treatment resulting from illegal activities
- Speech therapy
- Persons HIV+ at effective date
- Adult routine physical examinations are excluded under the Basic and Enhanced plan for the first 12 months
- Treatment as a result of terrorism, war or riot
- Charges which are not medically necessary, or are not performed by order of a physician

*This is only a consolidated and summary description of some of the current Azimuth Risk Solutions benefits, conditions, limitations and exclusions. An Evidence of Insurance containing the terms, conditions and exclusions will be included in the fulfillment kit. Azimuth reserves the right to issue the most current Evidence of Insurance for this plan in the event this application and / or brochure has expired, is modified, or is replaced with a newer version. A complete copy of the Master Policy is available at all times upon request.





8520 Allison Pointe Blvd, Suite 220
Indianapolis, Indiana 46250

Phone: 317-64 / 888-201-8850 Fax:
317-423-9620 / 88-201-8851

Email: service@azimuthrisk.com
Website: www.azimuthrisk.com

MERIDIAN CLEAR RATES

THE MERIDIAN SERIES – CLEAR WORLDWIDE COVERAGE EXCLUDING THE U.S. AND CANADA

All amounts are shown in U.S. dollars. Rates apply to all new business purchased on 10/03/2022 or later. Please be mindful of your deductible selection, as you will not have the option to select a lower deductible when you renew your coverage. Rates shown Do Not include surplus lines taxes (if applicable). Rates shown includes an administrative fee (\$3.00 per member per month). Azimuth Risk Solutions reserves the right to issue the most current rates online in the event these rates expire, are modified, or replaced with a newer version.

Deductible	US \$250		US \$500		US \$1,000		US \$2,500		US \$5,000		US \$10,000	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
14 days to 9 years	First 2 Free; thereafter \$505.00	First 2 Free; thereafter \$505.00	First 2 Free; thereafter \$431.00	First 2 Free; thereafter \$431.00	First 2 Free; thereafter \$339.00	First 2 Free; thereafter \$339.00	First 2 Free; thereafter \$307.00	First 2 Free; thereafter \$307.00	First 2 Free; thereafter \$278.00	First 2 Free; thereafter \$278.00	First 2 Free; thereafter \$255.00	First 2 Free; thereafter \$255.00
10-18	\$545.00	\$545.00	\$452.00	\$452.00	\$359.00	\$359.00	\$328.00	\$328.00	\$299.00	\$299.00	\$273.00	\$273.00
19-24	\$1,129.00	\$1,524.00	\$978.00	\$1,453.00	\$770.00	\$1,046.00	\$683.00	\$930.00	\$566.00	\$794.00	\$456.00	\$608.00
25-29	\$1,169.00	\$1,827.00	\$1,025.00	\$1,606.00	\$802.00	\$1,161.00	\$709.00	\$1,026.00	\$592.00	\$898.00	\$472.00	\$630.00
30-34	\$1,287.00	\$1,894.00	\$1,136.00	\$1,778.00	\$892.00	\$1,333.00	\$794.00	\$1,182.00	\$656.00	\$1,003.00	\$526.00	\$759.00
35-39	\$1,335.00	\$2,094.00	\$1,189.00	\$1,907.00	\$928.00	\$1,475.00	\$826.00	\$1,297.00	\$683.00	\$1,113.00	\$543.00	\$779.00
40-44	\$1,710.00	\$2,292.00	\$1,516.00	\$2,053.00	\$1,182.00	\$1,599.00	\$1,052.00	\$1,424.00	\$867.00	\$1,140.00	\$693.00	\$905.00
45-49	\$1,920.00	\$2,385.00	\$1,718.00	\$2,154.00	\$1,340.00	\$1,683.00	\$1,193.00	\$1,495.00	\$982.00	\$1,161.00	\$780.00	\$918.00
50-54	\$2,325.00	\$2,584.00	\$2,100.00	\$2,354.00	\$1,640.00	\$1,843.00	\$1,496.00	\$1,676.00	\$1,233.00	\$1,378.00	\$973.00	\$1,092.00
55-59	\$2,935.00	\$2,943.00	\$2,693.00	\$2,700.00	\$2,110.00	\$2,116.00	\$1,864.00	\$1,871.00	\$1,576.00	\$1,579.00	\$1,239.00	\$1,241.00
60-64	\$4,110.00	\$3,999.00	\$3,805.00	\$3,681.00	\$3,191.00	\$3,049.00	\$2,917.00	\$2,783.00	\$2,425.00	\$2,216.00	\$1,997.00	\$1,839.00
65-69	\$8,450.00	\$7,603.00	\$8,141.00	\$7,287.00	\$7,530.00	\$6,654.00	\$5,863.00	\$5,469.00	\$5,092.00	\$4,731.00	\$4,202.00	\$3,907.00
70-74	Please Contact Azimuth Risk Solutions For Rates											

OPTIONAL RIDERS: EXTREME SPORTS RIDER= \$302.00 DENTAL RIDER (ADULT)= \$518.00 (CHILD)= \$345.00 ALL OPTIONAL RIDERS ARE IN ADDITON TO THE BASE PREMIUM COST

THE MERIDIAN SERIES – CLEAR WORLDWIDE COVERAGE INCLUDING THE U.S. AND CANADA

All amounts are shown in U.S. dollars. Rates apply to all new business purchased on 10/03/2022 or later. Please be mindful of your deductible selection, as you will not have the option to select a lower deductible when you renew your coverage. Rates shown Do Not include surplus lines taxes (if applicable). Rates shown includes an administrative fee (\$3.00 per member per month). Azimuth Risk Solutions reserves the right to issue the most current rates online in the event these rates expire, are modified, or replaced with a newer version.

Deductible	US \$250		US \$500		US \$1,000		US \$2,500		US \$5,000		US \$10,000	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
14 days to 9 years	First 2 Free; thereafter \$674.00	First 2 Free; thereafter \$674.00	First 2 Free; thereafter \$574.00	First 2 Free; thereafter \$574.00	First 2 Free; thereafter \$445.00	First 2 Free; thereafter \$445.00	First 2 Free; thereafter \$405.00	First 2 Free; thereafter \$405.00	First 2 Free; thereafter \$367.00	First 2 Free; thereafter \$367.00	First 2 Free; thereafter \$335.00	First 2 Free; thereafter \$335.00
10-18	\$731.00	\$731.00	\$603.00	\$603.00	\$476.00	\$476.00	\$433.00	\$433.00	\$392.00	\$392.00	\$357.00	\$357.00
19-24	\$1,527.00	\$2,039.00	\$1,282.00	\$1,916.00	\$1,033.00	\$1,398.00	\$915.00	\$1,242.00	\$758.00	\$1,057.00	\$606.00	\$806.00
25-29	\$1,578.00	\$2,272.00	\$1,388.00	\$2,148.00	\$1,079.00	\$1,551.00	\$955.00	\$1,369.00	\$791.00	\$1,198.00	\$626.00	\$834.00
30-34	\$1,740.00	\$2,540.00	\$1,534.00	\$2,382.00	\$1,203.00	\$1,781.00	\$1,072.00	\$1,578.00	\$883.00	\$1,337.00	\$703.00	\$1,010.00
35-39	\$1,802.00	\$2,809.00	\$1,608.00	\$2,557.00	\$1,249.00	\$1,974.00	\$1,118.00	\$1,734.00	\$915.00	\$1,487.00	\$729.00	\$1,035.00
40-44	\$2,314.00	\$3,076.00	\$2,053.00	\$2,752.00	\$1,597.00	\$2,143.00	\$1,423.00	\$1,909.00	\$1,165.00	\$1,524.00	\$930.00	\$1,203.00
45-49	\$2,600.00	\$3,197.00	\$2,332.00	\$2,888.00	\$1,813.00	\$2,256.00	\$1,610.00	\$2,001.00	\$1,322.00	\$1,551.00	\$1,052.00	\$1,225.00
50-54	\$3,152.00	\$3,468.00	\$2,843.00	\$3,156.00	\$2,220.00	\$2,470.00	\$2,030.00	\$2,247.00	\$1,670.00	\$1,843.00	\$1,315.00	\$1,456.00
55-59	\$3,982.00	\$3,951.00	\$3,656.00	\$3,623.00	\$2,862.00	\$2,837.00	\$2,529.00	\$2,509.00	\$2,135.00	\$2,115.00	\$1,675.00	\$1,660.00
60-64	\$5,586.00	\$5,373.00	\$5,165.00	\$4,946.00	\$4,332.00	\$4,095.00	\$3,959.00	\$3,742.00	\$3,289.00	\$2,973.00	\$2,712.00	\$2,462.00
65-69	\$11,490.00	\$10,232.00	\$11,075.00	\$9,804.00	\$10,239.00	\$8,949.00	\$7,971.00	\$7,353.00	\$6,922.00	\$6,359.00	\$5,710.00	\$5,250.00
70-74	Please Contact Azimuth Risk Solutions For Rates											

OPTIONAL RIDERS: EXTREME SPORTS RIDER= \$302.00 DENTAL RIDER (ADULT)= \$518.00 (CHILD)= \$345.00 ALL OPTIONAL RIDERS ARE IN ADDITON TO THE BASE PREMIUM COST

MERIDIAN CLEAR APPLICATION



Going Your Way





THE MERIDIAN CLEAR APPLICATION

The Meridian Clear Insurance PlanSM 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 sm (Azimuth).

Important Information

The Meridian Clear 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 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.

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 mailed, such as fulfillment kit, renewal forms, and any claims information. You may also elect to receive your insurance documents by email by checking the box "I would like to receive my insurance documents electronically".

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**

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. 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.

4. 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.

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.

MERIDIAN CLEAR				
Coverage Area	Deductibles	Dental Rider	Sports Rider	Express Delivery \$25.00 (US) \$35.00 (All Others)
Including US/Canada	<input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 2500	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> \$ 25
	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 5,000	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> \$ 35
	<input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 10,000			
Excluding US/Canada	<input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 2500	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> \$ 25
	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 5,000	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> \$ 35
	<input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 10,000			
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).

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(Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
B. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
C. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
D. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
E. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
F. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
G. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
H. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
I. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					
J. (Last, First, Middle)	<input type="checkbox"/> Male <input type="checkbox"/> Female					

RESIDENCE ADDRESS

STREET ADDRESS:		CITY, STATE, POSTAL CODE:
COUNTRY:	TELEPHONE:	<input type="checkbox"/> 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 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, COUNTRY:	TELEPHONE:	
EMAIL:		
IF YOUR RESIDENCE ADDRESS OR YOUR MAIL FORWARDING ADDRESS IS IN FLORIDA, IS THE APPLICANT CURRENTLY LOCATED IN FLORIDA? <input type="checkbox"/> Yes <input type="checkbox"/> 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.	If Yes, show family member by using letters from Section 1	
1. Are you or any other applicant currently disabled, pregnant, or unable 1. to perform normal activities?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Are you or any other applicant presently hospitalized, or scheduled for or in need of hospitalization or surgery?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. 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 <input type="checkbox"/>	No <input type="checkbox"/>
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past twelve (12) months, other than basal cell carcinoma or squamous cell carcinoma?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Have you or any other applicant ever been diagnosed with or treated for Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, cerebral palsy, paralysis, . or transient cerebral ischemic attacks (as it relates to the conditions listed in this question)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Have you or any other applicant ever been diagnosed with or treated for muscular or skeletal system disorders (including but not limited to: scoliosis, osteoporosis, disc disease, vertebrae or back disease or disorders, rheumatism, fibromyalgia, rheumatoid arthritis, gout, or chronic tendonitis)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If any individual answered YES to any of the above questions, he or she does not qualify for this insurance. Thank you for your interest. If you've 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.	IF YES, SHOW FAMILY MEMBER USING LETTERS FROM SECTION 1	
8. Have you or any other applicant ever been diagnosed with or treated for heart, cardiac, cardiovascular and/or circulatory, including, but not limited to: congestive heart failure, heart attack, angina, arteriosclerosis, atherosclerosis, thrombosis, phlebitis, rheumatic fever or chest pain (as it relates to the conditions listed in this question)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Have you or any other applicant been diagnosed with or treated for epilepsy, convulsions, seizure, stroke, migraines and/or chronic headaches?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Have you or any other applicant been diagnosed with or treated for carpal tunnel syndrome and any advanced disease or disorder of the tendons, cartilage, bone or joints?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Have you or any other applicant been diagnosed with or treated for thyroid, breast or other glands in the past 10 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Have you or any other applicant been diagnosed with or treated for elevated blood pressure, hypertension, hypotension, heart murmur, or swelling of the feet/ankles in the past 10 years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14. Have you or any other applicant consulted a mental health professional or received inpatient or outpatient mental health advice or treatment during the last five (5) years for any mental health condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Have you or any other applicant experienced a weight change of 20 pounds or more in the last twelve (12) months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Have you or any other applicant used tobacco of any form in the last twelve (12) months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. 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 arrest in the past five (5) years?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Have you or any other applicant been diagnosed with or treated for any other disease, medical problem, illness, injury or condition of any kind not listed above?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If any individual answered YES to any of the above questions, he or she may not qualify for this insurance. Please note, coverage may be offered with a Medical Rider or Conditional Rate Up for coverage. All questions answered Yes, must be explained in detail in Section 3 of this 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 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 all 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 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 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, 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 (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 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.

Signature of Applicant, Guardian or Proxy

Date (Mo./Day/Yr.)

Signature of Spouse

Date (Mo./Day/Yr.)

SECTION 4.

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	\$	\$	\$	\$
B.	\$	\$	\$	\$
C.	\$	\$	\$	\$
D.	\$	\$	\$	\$
E.	\$	\$	\$	\$
F.	\$	\$	\$	\$
G.	\$	\$	\$	\$
H.	\$	\$	\$	\$
I.	\$	\$	\$	\$
J.	\$	\$	\$	\$
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)
 \$ X = \$ + Optional express mailing fee (\$25 in US, \$35 outside US): \$
 (Subtotal A) *Modal Factor Total
Total First Payment Due: \$

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

Modal factors:
 ANNUAL = 1.00
 SEMI-ANNUAL = 0.55
 QUARTERLY = 0.28
 MONTHLY = .10
(Please select a payment mode)
 \$ X = \$
 (Subtotal A) *Modal Factor 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.

SECTION 5

Method of Payment

<input type="checkbox"/> Check (annual only) <input type="checkbox"/> Money Order (annual only) <input type="checkbox"/> Visa Card <input type="checkbox"/> Master Card <input type="checkbox"/> American Express <input type="checkbox"/> Card Discover Card		
<p>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.</p>		
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 Insurance Trust (Anguilla) and for the insurance provided to Participating Members by Lloyd's, 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 Pre-existing 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 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.

Signature of Applicant, Guardian or Proxy

Date (Mo./Day/Yr.)

Signature of Spous

Date (Mo./Day/Yr.)

SECTION 6

Insurance Agent/Broker Use Only

Azimuth Agent Number: 9c032e8d		Azimuth Agent Name: Hamilton Hudson	
Company Name: Hamilton Hudson Roatan Healthcare			
Company Address: Roatan 34101		City, State, Postal Code: Bay Island ,	
Phone: 1.616-855-7670	Fax: +1 212 898 1303	Country: Honduras	
Website: http://www.hamiltonhudson.com		Email: info@HamiltonHudson.com	
Agent/Broker Signature:			



8520 Allison Pointe Blvd, Suite 220,
Indianapolis, IN 46250 USA



Phone: 317-644-6291/888-201-8850
Fax: 317-423-9620/888-201-8851



Email: service@azimuthrisk.com
Website: www.azimuthrisk.com