THE CONTOUR GROUP MEDICAL PLAN
ENROLLMENT/CHANGE FORM

THIS FORM IS FOR:	Employee Only		
Participating Organization:	Volunteer Missionary Movement	Organization Contact Email:	vic@vmmusa.org
Agent Of Record Name:	Insurance Services of America	Agent Of Record Email:	grace@isabrokers.com
Employee Name (Last First Middle) :	Kelsey L Schrock		

Occupation: Missionary	Citizenship: United States	Gender: Female	Height: 5 Ft. 6 Inches	Weight: 150-Pounds

Resident Street Address: 5434 Johnson Iowa Rd	Resident City / State / Postal or Zip Code: Wellman, IA 52356
Telephone Number: 319-646-2832	Email: kelseyschrock@gmail.com
Identification Number / Social Security Number: 482-19-5490	Date of Birth: 03/09/1991

REQUESTED EFFECTIVE DATE (DD/MM/YY): 09/09/2013	Date Employed Full Time: 09/09/2013	Hours Worked Per Week: 30-40
Departure Date from U.S. : 09/09/2013	Country of Destination: Nicaragua	Length of Stay: 2 years

The Contour Group Medical Plan is a surplus lines product underwritten by Certain underwriters at Lloyd's, London. It is distributed, managed and administered, as agent for and on behalf of certain underwriters at Lloyd's, London, by Azimuth Risk Solutions, LLC sm.

Questions Answers

The questions below must be answered for the applicant and every family member included on the Application. For any question answered "Yes," please identify to whom the answer applies (use the number that corresponds to the family member from Part 1), and provide complete details of the medical condition at issue in the space provided in Part 4 of this Application, including the name, address and telephone number of all attending physician(s), diagnoses, all treatment dates, type(s) of treatment, prognosis, and present course of treatment.

1. Are you or any other applicant currently pregnant, hospitalized, or disabled?	**No**
2. Have you ever been diagnosed, treated or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome or any immune system Disorder?	**No**
3. Have you or any other applicant or any other applicant ever been diagnosed, treated (including medications) or tested for: cancer, diabetes, high blood pressure, neurological, or any cardiac, cardiovascular, heart, or circulatory condition?	**No**
4. During the last 24 months have you or any other applicant been diagnosed, treated (including medications) or tested for any medical, mental or nervous condition or problem?	**No**
5. During the last 24 months have you or any other applicant been advised or recommended to have testing, treatment or surgery or do you anticipates testing, treatment or surgery for any medical or mental or nervous condition or problem?	**No**
6. Gallbladder, pancreas, or liver?	**No**
7. Joints or spine?	**No**
8. Eyes, ears, or nose?	**Yes**

Name: Kelsey Schrock	**Condition:** Frequent nose bleeds	**Date of Treatment:** 10/01/2008	**Prognosis:** Nose Canterization Fully recover	**Physician:** Dr. Simpson, ENT 2615 Northgate Dr, Iowa City, IA 319-351-5680

9. Mouth, throat, or jaw?	**No**
10. Chest pain?	**No**
11. Headaches, paralysis, or arthritis?	**No**
12. Convulsions or epilepsy?	**No**
13. Elevated cholesterol?	**No**
14. Cancer or stroke?	**No**
15. Kidney or urinary system?	**No**

16. Thyroid, breast, or other glands?	**No**
17. Complicated pregnancy or delivery?	**No**
18. Tumor, cyst, polyp, or growth of any kind?	**No**
19. Sexually Transmitted disease?	**No**
20. Heart or circulatory system?	**No**
21. Respiratory system?	**No**
22. Nervous system?	**No**
23. Digestive system?	**No**
24. Prostate?	**No**
25. Muscular or skeletal system?	**No**
26. Reproductive system?	**Yes**

Name: Kelsey Schrock	**Condition:** Polycystic ovary syndrome	**Date of Treatment:** 12/01/2011	**Prognosis:** Ultra sound No treatment	**Physician:** Dr. Ward, OBG 200 Hawkins Dr, Iowa City, IA 319-356-2294

27. Alcohol or drug dependency?	**No**
28. Mental health or psychological?	**No**
29. Diabetes or sugar or blood in urine?	**No**

Beneficiary Information

Beneficiary Name:	Primary/Contingent	Relationship to Employee:	Percent of Death Benefit:
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PART 6

Has any person listed on this Enrollment Form, including dependents, been insured or covered for medical expenses under any individual or group policy or plan during the last 12 months? Yes

If you answered Yes, the following is required: 1. Name of Person(s) 2. Copy of Creditable Coverage. 3. Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Failure to submit Certificates of Creditable Coverage may delay your Effective Date.

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 this insurance contains a Pre-existing Condition exclusion, a Pre-certification Requirement and other restrictions and exclusions as indicated by the plan schedule of benefits unless otherwise noted. I (we) understand that no insurance will be made effective until this Application has been duly accepted in writing by an officer of the Scheme Administrator or Certain Underwriters, Lloyd's. I (we) understand that this insurance is not intended or considered to be resident, located, or to be performed in any particular state of the United States of America, and 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 (we) 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. I (we) understand that the information contained herein is a summary of benefits and that I may obtain a complete copy of the Master Policy upon request to Azimuth Risk Solutions, LLC.

ACKNOWLEDGEMENT I (we) understand and agree that: (i) the insurance agent/broker soliciting, assigned to or assisting with this Application is the representative of applicant(s), (ii) this insurance does not provide benefits for 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 years prior to the effective date 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 (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or ARS to be resident, located, or expressly to be performed in any particular state of the United States, and (iv) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided under the insurance contract. 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 ARS and/or the Company.

CERTIFICATION

I (we) hereby certify, represent and warrant that : (i) I (we) have read the foregoing statements and the brochure or that they have been read to me (us), and I (we) understand them, (ii) I am (we are) eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) I am (we are) currently in good health and 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 or other medical condition which I (we) foresee may require treatment during this insurance or for which I (we) intend to claim under this insurance. If 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 applicant. Payment must be made for the total number of months you want coverage. All payments must be made in U.S.D. and drawn on U.S. banks.

MEDICAL RELEASE

I (we) 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 of any physical or mental condition, and/or employment status, to provide such information to ARS and/or the Company.

Employee Signature: Kelsey Schrock Date: Aug 26 2013

Spouse Signature: Date: Aug 26 2013