

THE CONTOUR GROUP MEDICAL PLAN ENROLLMENT/CHANGE FORM

THIS FORM IS FOR:	IIS FORM IS FOR:							Employee + Spouse					
Participating Organization:	Caribb	ustice			Organization Contact Email:			nail:		gmarcano@tticltd.com			
Agent Of Record Name:	Anthony N.V. Slinger			∍r			Agent Of Record Email:				nslinger@tticltd.com		
Employee Name (Last First Middle) : Maure													
Occupation: JUDGE	Citizenship: Trinidad Tobago	And	Gender: Fe	emale		Height: 5 Ft. 5 Inches				Weight:	160-Pounds		
Resident Street Address: 102 Grapefruit Crescent Haleland P	AGO, WEST IN				City / State / Postal or Zip Code:								
Telephone Number: 868-629-2161			Email:			mrajnauthlee@gmail.com					gmail.com		
Identification Number / Social Secur	dentification Number / Social Security Number: 1			19531029037			Date o	f Birth:		10/29/1953			
REQUESTED EFFECTIVE DATE (DD/MM/YY): 03/27/2015			Date Employed Full Time: 03/27/2015			Hours V			'''	: Worked Per Week:			
Departure Date from U.S.:			Country of Destination: Grenada			Length			Length o	of Stay:			
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.													
DEPENDENTS													
Name (Last, First, Middle)	Gender			Date of Birth			Citizenship						
Spouse: LEE, DAVID JUSTIN		Male	10/24/1949			Trinidad And Toba			nd Tobago				
Identification Number:	19491024029		Height			nt: 75 Centimeters			Weight:	150-Pound	ds		
For dependent children age 19 or	older, please indicate r	ame and addr	ress of coll	lege or	universi	ty and	the nu	mber of hou	urs enrolle	ed below:			
I refuse coverage for : Reas				Reason:									
I have been given the opportunity to understand that if coverage is desir HERE ONLY IF REFUSING COVE	ed at a later date, I may b											SIGN	
Signature:	Date:												
Printed Name:													
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

2. Have you ever been diagnosed, treated or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex

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, Yes

1. Are you or any other applicant currently pregnant, hospitalized, or disabled?

(ARC), Lymphadenopathy Syndrome or any immune system Disorder?

Rajnauth- Lee (2)	Maureen HYPERTENSION 140/80 Treatment: MG ANI				GAND EXERCISE (2) Diagnosed as being stress FAMIILY CARE					(AN ABRAHAM, SERPENTINE RO T CLAIR, TRINIDAD(868)622-734 Gordon Street, Port of Spain 625-34	0 (2) Dr			
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? Yes														
MAUREEN MINISCUS TEAR AND ARTHRITIS TO Treatment: DIET S						nosis: PROBLEM TREATED WITH Physician: DR TERRY ALI WESTSHORE MEDICAL CENTRE SUPPLEMENTSNO MEDICAL WESTERN MAIN ROAD, PORT OF SPAIN, TRINIDAD (868)622-9878 Dr Samantha Bhagan. Woodbrook. 625-9883								
	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, pand	reas, or liv	/er?									Yes			
Name: Condit MAUREEN VIRAL HEPAT	tion: #6,	Treatment: FURTHER TREATMENT was REQUIRED ELIZABETH STREET PORT OF SPAIN, TRINIDAD AND TOBAGO (868)628-1								28-1451				
7. Joints or spine?											Yes			
MAUREEN RAJNAUTH LEE DAVID J LEE Condition: SLIGHT MENISCUS TEAR TO LEFT FROM THREADMILL EXERCISE Neck Pain Do 2005 Surgical Repair to Left Achilles Tendon Aug 2010Slight Menicus Tear -Left Knee				Dec	Date of Treatmer 06/01/201	nt: SUPF I5 MRI f requii	nosis: TREATING WITH PLEMENTS AND MODE or Neck Pain (no further red) NO FURTHER TREA ESSARY	RATE EXEF treatment w		Physician: DR Terry Ali, Westshore Medical Centre, Western Main Road, Trinidad and Tobago(868)622-9878 Dr Ryan Abraham Serpentine Medical DR. Terry Ali				
8. Eyes, ears, or nos	se?										No			
9. Mouth, throat, or	jaw?										No			
10. Chest pain?											Yes			
Name: Maureen Ra Lee	P	condition: Chest Pain	Date of Trea 07/01/2005	atment:		ognosis: juired	Stress Relatedno treat	ment was	Physician 625 -3445	n: Dr Judith Henry, 31 Gordon Stree	t, P.O.S.			
11. Headaches, para											Yes			
Name: Maureen Ra Lee		Condition: Left Kn Arthritis		te of Trea /01/2015	atment:		rognosis: Did an MRIr equired	no further tre	eatment	Physician: Dr Terry Ali. (see ab details)	ove for			
12. Convulsions or e	epilepsy?										No			
13. Elevated cholest	terol?										No			
14. Cancer or stroke	?										No			
15. Kidney or urinary											Yes			
Name: Maureen Rajnauth_Lee		ondition: Urinary T ersistent)	ract Infection		te of Treat 01/2014	ment:	Prognosis: Treate antibiotics	ed with	Physicia address of	n: Dr Samantha Bhagan (see abov details)	e for			
16. Thyroid, breast,	or other gl	ands?									No			
17. Complicated pre	gnancy or	delivery?									Yes			
Name: Maureen Ra Lee	•	Condition: Delivere 1982)	ed 3 boys by (C Sections	s (1977, 19		e of Treatment: 07/1977	Prognos None		ysician: Delivery by Medical staff a its	t Maternal			
18. Tumor, cyst, poly	yp, or grov	vth of any kind?					18. Tumor, cyst, polyp, or growth of any kind?							
Name: David J Lee Condition: Small pedunculated polyps on Two occasionslast done on October 2015 Rajnauth_Lee (2) Fibroids				2015. Treatment: colonoscopy (2) Found on routine examinations. Spain 62:						sician: Dr Gerard Farfan Woodbroo				
		casionslast done o)15. Tre	atment:	colonos	copy (2) Found on routing		ons. Spaii	n 622-2223 (2) Dr Leola Weithersl n, 625-9883				
	(2) Fibro	casionslast done o)15. Tre	atment:	colonos	copy (2) Found on routing		ons. Spaii	n 622-2223 (2) Dr Leola Weithersl				
Rajnauth_Lee 19. Sexually Transm 20. Heart or circulate	(2) Fibro nitted disea ory system	casionslast done o oids ase? n?	on October 20	015. Tre	atment: 01/2006	colonos no treati	copy (2) Found on routing	e examinati	ons. Spaii Spaii	n 622-2223 (2) Dr Leola Weithersl n, 625-9883	No Yes			
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Beneficiary Name:	Primary/Contignent	Relationship to Employee:	Percent of Death Benefit:	
Allan James Lee	Contingent	Son	50%	

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?

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: Maureen Rajnauth-Lee Date: May 07 2015

Spouse Signature: David Justin Lee Date: May 07 2015