The LIFEBOAT Medical Insurance Plan

As described in the brochure and documentation, Lifeboat Medical Insurance Plan is a comprehensive medical insurance program designed exclusively for the international citizen. In order to provide you and your family with the coverage you desire, please follow the directions and answer all questions in complete detail**.**

Please note that Lifeboat limits coverage in the United States to 180 days during any given 364 day policy period. This plan is not intended to cover permanent residents of the United States.

IMPORTANT NOTICES: Directions for completing the application:

1. Please print or type all information. Illegible information will delay underwriting and processing of your coverage.
2. Each family member requesting coverage must be listed on the Application. All questions on the Application apply to all applicants requesting coverage. Answer each and every question as it pertains to each applicant listed on the Application. All members of a family must choose the same Deductible.
3. Each section of the application must be completed in full. Any question where a "YES" was marked must be described in detail in Section 3. Information in Section 3 must include the applicant's name, physician's name, address and phone number, address of treating facility, diagnosis, prognosis, and course of treatment. If necessary, use an additional sheet of paper to describe the condition(s) and attach it to the Application when submitted to Seven Corners, Inc.
4. The Premiums listed on the enclosed rate card are annual premiums and can be paid by check, money order, VISA or MasterCard. **Due to the questionable reliability of international mail, semi-annual and quarterly payments can only be made by using a credit card.** Semi-annual and quarterly payment modes are only accepted with preauthorization to debit your credit card on the due date of your premium installment. Checks are only acceptable on a U.S. bank.
5. Once Seven Corners underwrites your application and determines that coverage should be issued, we will send you an ID Card and a Certificate of Coverage by mail. The Certificate of Coverage contains the full program wording and definitions. This package will also include details concerning procedures for claims submission and the importance of Seven Corners pre-notification procedures.

The LIFEBOAT Medical Insurance Plan Application

All Sections Must Be Completed in Full

Section 1. Applicant Information:

Applicant's Name (Last, First, Middle, Maiden)	Sex	Relationship	Date of Birth (Mo/Day/Yr)	Citizenship Country	Height Feet / Inches	Weight lbs
		Primary Insured				
		Spouse				
		Child				
		Child				
		Child				

Residence Address: (must be outside the United States - street, city, state, country, postal code):	
Mailing Address: (street, city, state, country, postal code):	

Home Phone:	Business Phone:
Fax:	E-Mail Address:
Occupation of Primary Insured:	Occupation of Spouse:
Previous Occupation:	Name of Employer:
Family Physician Name, Address, and Telephone Number **(Required)**:	

	Yes	No
Do you understand this is an international program and not U.S. health insurance?		
Do you understand that you are unable to be in the U.S. longer than 180 days during any given 364 day period?		
When do you plan to depart the United States: _____ / _____ / _____ (month/day/year)		
Are all listed dependents who are age 19, 20, 21, 22 and 23 full time students? (if yes, please list schools and locations)		

Section 2.Health History Questions for Applicants

In order for your Application to be processed successfully, each question must be answered truthfully. Any answers to "yes" questions must be clarified in Section 3 Health History Details. In addition, answers to "yes" questions require an Attending Physicians Statement (APS) dated within the past 90 days. All questions for all applicants must be answered and sufficient medical data reported in order for Seven Corners to underwrite your application.

Within the past ten (10) years, have you or any applicant been medically advised, referred, counseled, treated, had surgery or been treated, diagnosed or currently taking prescription medical for: (Please 'check' all that apply and state in detail in Section 3. Health History Details.)	**Yes**	**No**
1. Digestive system diseases or disorders (including, but not limited to: gastritis, ulcers, esophageal regurgitation, hemorrhoids, colon or rectum disorders)?		
2. Cardiovascular and/or circulatory diseases or disorders (including, but not limited to: elevated blood pressure, hypertension, elevated cholesterol, heart attack, angina, chest pains, arteriosclerosis, coronary insufficiency, thrombosis, phlebitis, vascular afflictions, rheumatic fever, heart murmur)? If "Yes" attach Attending Physicians Statement (APS) and current blood pressure reading, dated within the past 90 days describing the cardiovascular and/or circulatory condition.		
3. Respiratory diseases or disorders (including, but not limited to: chronic cough, bronchial asthma, bronchitis, tuberculosis, lung disorders, emphysema, respiratory insufficiency, pleurisy pneumonia)?		
4. Diseases or disorders of the eyes, nose, ears and throat (including, but not limited to: nasal septum deviation, chronic sinusitis, cataracts, glaucoma, allergies or hay fever)?		
5. Sexually transmitted diseases or immune deficiency disorder (AIDS / ARC), tested positive for HIV or any related illness?		
6. Diseases or disorders of the Pancreas, Liver, Gall Bladder or endocrine disorders (including, but not limited to: obesity, pituitary or lymph glands, thyroid or metabolic disorders)?		
7. Diabetes? (If "Yes", complete the following) a) Diabetic Type: ____ I or ____ II b) Date Diagnosed: ____ / ____ / ____ c) Medications: Type: _____ Dosage: _____ d) Controlled by diet only?: ____ Yes or ____ No e) Date of last HbA1c Test: _____ / ____ / ____ HbA1c Results (1-10): _____		
8. Diseases or disorders of the mental and nervous system (including, but not limited to: mental retardation, psychosis, mental or behavioral disorders, Down Syndrome or other chromosome disorders, depression, anxiety, chronic fatigue, eating disorders)?		
9. Neurological disorders (including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient ischemic attacks?		
10. Addictive diseases or disorders (including, but not limited to: alcoholism, chemical or drug abuse or addiction, or has any		

applicant used illegal drugs or used prescription medication, other than as prescribed)?		
11. Kidney or urinary tract system diseases or disorders (including, but not limited to: kidney or bladder stones and infections)?		
12. Cell or blood diseases or disorders (including, but not limited to: cancer, tumors, cysts, polyps or other growths of the skin or internal organs, hepatitis, leukemia or Kaposi's sarcoma)?		
13. Muscular or skeletal diseases or disorders and inflammation (including, but not limited to: scoliosis, arthritis, rheumatism, gout, tendonitis, joint or vertebrae disorders, osteoporosis)?		
14. Have you or any applicant consulted a therapist, physician, chiropractor, psychologist, or health care practitioner for medical advise, medical treatment and/or preventative care? Or have you or any applicant been hospitalized or undergone medical studies including but not limited to diagnostic tests, x-rays, electrocardiograms, radiology or blood work?		
15. For male applicants, diseases or disorders of the reproductive system, including but not limited to prostate or elevated PSA level?		
16. For female applicants, diseases or disorders of the reproductive system, including but not limited to vaginal bleeding, fibroids, nodules , fallopian tubes, ovaries or uterus?		
17. For female applicants, are you currently pregnant or had a complicated pregnancy or delivery? If currently pregnant, when is the expected due date? _____		
18. For female applicants, diseases or disorders of the breasts, including but not limited to cysts, nodules, calcifications or abnormal mammogram?		
19. Have you or any applicant ever been rejected, ridered, cancelled, or had premium increased for any Health, Life or Disability Policy?		
20. Are you or any applicant currently hospitalized, disabled or unable to perform normal activities?		
21. Any Congenital defect, physical disorder or deformity, or developmental problems not listed above?		
22. In the last 12 months, have you or any applicant used any form of tobacco? If "Yes" what form of tobacco? _____ Quantity: _____ How often: _____		
23. Have you or any applicant recently experienced any signs, indications, symptoms, diagnosis or treatment that would cause you to believe that you currently have a new medical conditions?		

Section 3. Health History Details for Applicants

List details for all "YES" answers to the Section 2 health history questions (use additional paper, if necessary). Incomplete answers may delay processing.

Name of Person and Question #	Condition / Diagnosis, Treatment Medication Prescribed and Results of Treatment	Dates Seen & Duration	Physician / Clinic Address and Telephone #

Section 4.Declaration and Enrollment Request / Authorization to Release Medical Information:

I hereby apply for the Lifeboat program and for the insurance provided by Certain Underwriters at Lloyds, London (the "Underwriter"). I hereby subscribe to the Global International Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters and Lloyd's, London.

I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto is complete and true to the best of my knowledge and belief. I understand that my qualification for insurance is based upon my answers and statements herein and that this information may be verified by Seven Corners, Inc. (the "Administrator"). I understand that no one has the authority to exclude or direct me to exclude any information sought by this form. I understand that the Administrator will rely on all information on this Application in determining whether or not to issue coverage and that any incorrect or incomplete information may result in a claim denial or loss of coverage.

I understand that benefits may be limited or excluded for conditions for which any insured person has received any medical diagnosis or treatment, or taken any medication, or realized the manifestation of a condition before his or her effective date, according to the pre-existing conditions limitations provisions of the plan.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my dependents to give Seven Corners, Inc. or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to, information about: physical condition(s), health history(ies), avocation(s), age(s), occupation(s), and personal characteristics. This authorization includes information about drugs, alcoholism, mental illness, or communicable diseases.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Administrator to determine eligibility for benefits. I ALSO AUTHORIZE the Administrator to release any information obtained to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize.

I UNDERSTAND that as a resident of a foreign jurisdiction, I may be subject to foreign laws with respect to the type and form of coverage in which I am enrolling. I also understand and agree that responsibility for complying with those foreign laws rests solely on me.

I UNDERSTAND that no coverage is effective until I am notified in writing by the Administrator and advised of the official Effective Date. I also UNDERSTAND that if I am not accepted for coverage by the Administrator, the sole obligation of the Administrator and the Underwriter is to return the premium. I also UNDERSTAND that coverage in the United States is limited to 180 days during any 364 day policy period. I also UNDERSTAND that Lloyds operates as an unauthorized insurer in most US states and that claims may not be made against any state guarantee fund. I UNDERSTAND and AGREE that this program is issued outside the United States and that the program does not comply with any US state insurance law.

I UNDERSTAND that this program is not, nor does it intend to be, a general United States health insurance policy.

I ALSO UNDERSTAND any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF APPLICANT OR GUARDIAN: _____ Date: _____

SIGNATURE OF PROPOSED APPLICANT's SPOUSE (if applicable): _____ Date: _____

Section 5.Program Specifics

Please Check Your Chosen Deductible:	$500 ☐ $1000 ☐ $2500 ☐ $5000 ☐
Requested Effective Date: _____ / _____ / _____ (month/day/year) (Effective Date must be within 60 days of application date)	
Add "Work Related Coverage Rider" ___Yes ___No Addition of this Rider will increase the premium by 10%	

For the AD&D benefit, the Primary Insured shall be the beneficiary of the certificate. If the benefit is utilized for the Primary Insured, his/her estate shall be the beneficiary. If this is not acceptable, please list the beneficiary:	

Section 6. Premium Calculation and Payment

Charter Yacht Society Member # : _____

I would like to become a CYS Beneficiary Member NOW for $25. You must be a CYS Member (☐ Full Member, ☐ Associate Member or ☐ Beneficiary Member) in order to take advantage of this special insurance offer.

Annual Premium for all Applicants: _____

Work Related Coverage Rider (if applicable) X 1.10

Sub-Total of Annual Premium = _____

Installment Factor (from right) X _____

Total Premium = _____

Membership (CYS) + _____

Total Submitted = _____

Premium Installment	Factors
Annual	1.00
Semi-Annual	.55
Quarterly	.28

Important: Checks accepted for Annual Premium ONLY and be written from a U.S. bank.

Underwritten by:
Certain Underwriters at Lloyds, London; Rated A- "Excellent" by A.M. Best

Method of Payment

Check ☐ Money Order ☐ MasterCard ☐ Visa ☐ Card# _____ Expiration Date: _____

Name as it appears on credit card: _____ CSV # (3 or 4 digit code on back of card) _____

Daytime Phone: _____

Signature: _____

Billing Address: _____

All premium payments must be made in U.S. dollars. Checks must be issued from a U.S. bank and made payable to "Kuffel, Collimore & Co". If paying by credit card, I authorize Kuffel, Collimore & Co. to debit my credit card for the total amount due. In the event that I have elected to *Pre-Authorize credit card payment installations, I hereby request and authorize Kuffel, Collimore & Co. to debit my credit card periodically as payment installments become due. This authorization will remain in effect until revoked by me in writing, and until Kuffel, Collimore & Co. actually receives notice. Coverage purchased by credit card is subject to validation and acceptance by credit card company. *For installment payment other than annual, I pre-authorize Kuffel, Collimore & Co. to debit my credit card for the proper installment amount on the due date of the installment.

Signature for Pre-Authorization of Installment Premiums: _____

Return all completed applications along with payment to:
Kuffel, Collimore & Co.
1434 Blume Drive, Elgin, IL 60124-8719
Toll Free: 1-(877)-335-1234 1-(630)-806-8032 Fax: 1-(630)-723-0882
Email: rtc@kuffelcollimore.com