

IC+
TERM LIFE INSURANCE FOR THE INTERNATIONAL MARKET

APPLICATION FOR INSURANCE

Proposed Insured		
Name		
Address		
Telephone No.	Fax No.	E-Mail:
Date of Birth:	Citizenship:	Sex:

Proposed Policy owner (if different)		
Name		
Address		
Telephone No.	Fax No.	E-Mail:

Reason for insurance (check applicable box):	
Personal/Family Protection	<input type="checkbox"/>
Inheritance tax	<input type="checkbox"/>
Private Residential Loan	<input type="checkbox"/>
Keyman	<input type="checkbox"/>
Commercial Loan	<input type="checkbox"/>

Occupation:				
Nature of Business or Occupation				
Rank and duties if a member of the Armed Forces				
Do your duties involve you in any way (other than clerical) with:				
The licensed trade or entertainment industry?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Working at heights, offshore, aviation (other than scheduled flights), diving or the fishing or mining industries, work requiring special safety precautions or any other activity which may be regarded as hazardous?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, give full details:				
Does your job require a license, eg driving?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Policy Details		
Term: Years	Principal Sum \$	Desired Effective Date:
Total Principal Sum under existing life insurance policies (please circle appropriate box):		

\$0 to \$100,000.	\$100,001 to \$250,000	\$250,001 to \$500,000	\$500,001 to \$750,000	Over \$750,001	
Are you currently purchasing or intending to purchase any other life insurance or have you done so within the last 12 months?				Yes	No
If yes, please provide details of companies, dates and amounts of insurance:					

Personal Details:		
Doctor who currently holds your medical records:		
Name		
Address		
Telephone No.	Fax No.	E-Mail
If you have changed doctors within the last 3 months, please provide the following information regarding your previous doctor:		
Name		
Address		
Telephone No.	Fax No.	E-Mail

Height:	Weight:	
Provide details to all "Yes" answers.		
	Yes	No
1. Have you <u>ever</u> had an application for health or life insurance voided, declined, canceled, rescinded or modified (including medical exclusion riders)?		
2. In the last 12 months, have you used tobacco in any form?		
3. In the last 12 months, have you experienced a weight change of 15 pounds or more?		
4. In the last 5 years, have you had any indication, diagnosis or treatment of an alcohol or drug dependency, problem or abuse or any alcohol or drug related arrest?		
5. In the last 5 years, have you consumed alcoholic beverages in excess of 14 drinks per week?		
6. Are you pregnant?		
7. Do you read, write, speak and understand English? If no, what is your primary language? _____		
8. In the last 12 months, have you taken medication or received medical advice or treatment of any kind?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of any disease or disorder of:		
9. Gallbladder?		
10. Pancreas or liver?		
11. Joints or spine?		
12. Kidney?		
13. Eyes, ears or nose?		
14. Mouth, throat or jaw?		
Within the last 10 years, have you had any indication, signs, symptoms, diagnosis or treatment of:		
15. High blood pressure?		
16. Chest pain?		
17. Headaches?		

18. Paralysis?		
19. Arthritis?		
20. Convulsions or epilepsy?		
21. Elevated cholesterol?		
22. Sexually transmitted disease?		
23. Cancer?		
24. Diabetes or sugar in the blood or urine?		
25. Stroke?		
26. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?		
27. Tumor, cyst, polyp, lump or growth of any kind?		
Within the last 10 years, have you:		
28. Had a complicated pregnancy or delivery?		
29. Tested positive for antibodies to the HIV virus?		
30. Been hospital confined, had surgery or discussed surgery?		
31. Consulted a mental health professional?		
Within the last 10 years, have you had any indications, signs, symptoms, diagnosis or treatment of any disease, disorder, or abnormality of the:		
32. Heart or circulatory system?		
33. Nervous system?		
34. Digestive system?		
35. Muscular or skeletal system?		
36. Respiratory system?		
37. Male or female reproductive system?		
38. Urinary system?		
39. Thyroid, breast or other glands?		
40. Within the last 10 years, have you had any signs, indication, symptoms, diagnosis or treatment of any other disorder, disease, injury or adverse finding or had any adverse or abnormal test results?		
For any question answered "Yes", please provide details of the condition including: treatment dates, name, address and telephone number of the treating physician, diagnosis, prognosis and present course of treatment. Attach additional pages if necessary. Additional information may be required.		
Have either of your parents or any brothers or sisters died from or suffered from heart disease, stroke, diabetes, cancer or a nervous disorder?"	Yes	No
If yes, provide details including relationship and age at time, and state if death resulted:		

Beneficiary (if other than Policy owner):		
Name		Relationship to Applicant:
Address		
Telephone No.	Fax No.	E-Mail:

Contingent Beneficiary:		
Name	Relationship to Applicant:	
Address		
Telephone No.	Fax No.	E-Mail:

Declaration/Application:	
<p>I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided by Certain Underwriters at Lloyds, London. I have personally completed this Application. I represent that the answers and statements on this Application are true, complete and correctly recorded. I understand that any misrepresentation contained herein will void my insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by MultiNational Underwriters, Inc. I understand that if this Application is not accepted, the sole obligation of the MultiNational Underwriters, Inc. is to return the premium to me. 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 MultiNational Underwriters, Inc.</p>	
Signature of Applicant:	
Date of Signature:	
Signature of Policy owner (if different):	
Date of Signature:	

IMPORTANT PAYMENT INFORMATION: Applications without premium will not be processed. MNUI will not accept checks or money orders for Quarterly or Semi-Annual payment modes. For Quarterly or Semi-Annual payment modes, MNUI will only accept a pre-authorized credit card. Checks, Money Orders or Credit Cards may be used for Annual payment mode. Please make all checks payable to: MULTINATIONAL UNDERWRITERS, INC.	
PREMIUM CALCULATION:	
$IC+TERM LIFE: \$ \underline{\hspace{2cm}} \text{ Annual Premium } \times \underline{\hspace{1cm}} *Modal Factor = \$ \underline{\hspace{2cm}}$	
Premium Due	
*Modal Factor: Annual = 1.00, Semi-Annual = .55, Quarterly = .28	
METHOD OF PAYMENT:	
<input type="checkbox"/> Check or Money Order (Annual Pay Mode Only) <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA <input type="checkbox"/> American Express	
<p>The check or Money Order should be payable to MultiNational Underwriters, Inc. All payments must be made in U.S. dollars. If paying by Credit Card. I authorize MultiNational Underwriters, Inc. to debit my VISA/MasterCard/American Express account for the total amount due. If I have elected Semi-Annual or Quarterly payment modes, I hereby request and authorize MultiNational Underwriters, Inc. to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for up to 12 months or longer if the Certificate is renewed, or until revoked by me in writing. Coverage purchased by Credit Card is subject to validation and acceptance by the Credit Card company.</p>	
Credit Card Number:	Expiration Date:
Name as it appears on card:	Daytime Phone #:
Billing Address:	
Signature:	

Producer Number: 99985-0019	Producer Name: Anthony Moschella	
Company Name: Life & Health Quote Corp.	Street Address: 328 Hillside Avenue	
City: Williston Park	State: NY	Postal Code: 11596
Country: United States	Telephone: 1-866-786-8363	Fax: 1-516-746-2477
E-Mail: quote@optonline.net	Signature:	Date: