

WORLDWIDE MEDICAL TRUST/LLOYD'S APPLICATION FOR DISABILITY INSURANCE

PAYMENT MODE			
ANNUAL	<input type="checkbox"/>	CHECK	<input type="checkbox"/>
SEMI ANNUAL	<input type="checkbox"/>	CREDIT CARD	<input type="checkbox"/>

APPLICANT'S NAME			RELATIONSHIP	SEX	DATE OF BIRTH			AGE	HEIGHT	WEIGHT
FIRST NAME	I.	LAST NAME			DAY	MTH	YEAR			
1										
2										
3										
4										
5										
6										
7										
8										

	APPLICANT'S NAME	MONTHLY BENEFIT	PREMIUMS PER PERSON	TOTAL PREMIUMS
1				
2				
3				
4				
5				
6				
7				
8				
	TOTALS:		\$	\$

Permanent Residence (Including City & State)	Mailing Address	Telephone Number
		Fax Number
	Email Address	

Employer's Name and Address	Occupation and Duties	Telephone Number
		Fax Number
	Email Address	

PREMIUMS (A)	\$	ANNUAL PREMIUM	\$
	\$	MODAL FACTOR	X
		PREMIUM DUE	\$

1. HAS ANY PERSON PROPOSED FOR COVERAGE EVER BEEN ADVISED TO OR, RECEIVED MEDICAL CONSULTATION, CARE, TREATMENT OR, TAKEN MEDICATION FOR: <i>(Please circle each condition)</i>	YES	NO	Give full details on "yes" answers of each applicant including diagnosis, dates, duration, names and addresses of all attending physicians and medical facilities.
a. Heart or circulatory system, chest pain, high blood pressure, angina, shortness of breath, rheumatic fever, cardiac defect, disease of veins or arteries?			
b. Pulmonary disease, asthma, bronchitis, chronic cough, tuberculosis or allergies?			
c. Disease or disorder of spleen, pancreas, stomach, intestines, liver, gallbladder, ulcer, colitis, hemorrhoids, colon hepatitis, diverticulitis?			
d. Kidney disorders, urinary tract diseases, albumin or blood in urine, bladder disorders?			
e. Musculoskeletal or back disorders, rheumatism, arthritis, gout, lumbago, osteoporosis, deformity, hernia or any skin disorders?			
f. Cancer, tumors, any blood disorders or leukemia?			
g. Otitis, septal deviation, nasal trauma?			
h. Endocrine or thyroid disorders, goiter, diabetes, sugar in urine, swelling of lymphatic nodes?			
i. Sexually transmitted disease, or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex)?			
j. Disorders of the menstrual cycle, breasts, ovaries, uterus, fallopian tubes, cervix, vagina, miscarriages, cesarean sections, or others.			
k. Diseases or disorders of the reproductive system, prostate, testes, pelvic inflammatory disease, endometriosis, or others.			
l. Convulsions, epilepsy, attacks, paralysis, or any neurological disorders?			
a. Had health examinations or routine medical check-ups? Any abnormalities?			
b. Been a patient in a hospital, clinic or sanitarium been recommended to undergo a surgery that is still pending?			
c. Is anyone currently taking any prescribed medication or under medical treatment or have been advised of the possibility or necessity of future treatment or is currently addicted to drugs or alcohol? Please explain.			
d. Received treatment for any disorder or condition not mentioned above?			
e. Is anyone presently covered by another insurance company for either Disability or AD&D?			Company's Name:
f. Does any person proposed for insurance intend to replace or change an existing policy in connection with this application?			
g. Ever been disabled for a period of 90 days or more or made a claim on any disability insurance?			Expiration Date: ____/____/____
h. Currently in good health and free from physical defect or injuries?			

3. Family or personal physician:		4. Students: Full time students, between the ages of 18 and 25 years old.	
Name::		Student's Name:	College/University
Address::			
Phone::		Fax:	
		<i>Proof of Student status must be submitted</i>	

CREDIT CARD PAYMENT AUTHORIZATION

<input type="checkbox"/> Visa	<input type="checkbox"/> Mastercard	<input type="checkbox"/> Other	Name:
<input type="checkbox"/> Amex	<input type="checkbox"/> Diners		
Credit Card Number: _____ / _____ / _____ Expiration Date: ____ 20____ Amount: US\$ _____			Address:

I, the undersigned, authorize Morgan-White Administrators International, Inc., until contrary written notice otherwise, to charge non-specified amounts to my credit card related to my insurance premiums, as and when they become due.

I also authorize Morgan-White Administrators International, Inc., until contrary written notice otherwise, to charge non-specified amounts to my credit card related to the payment of the insurance premiums as and when they become due for the policies of my following dependents:

Name:

Relationship to credit card holder:

Date: _____ / _____ / 20_____

Signature: _____

Please make cheques payable to: WORLDWIDE MEDICAL TRUST/LLOYD'S

