



# Application Form

**Important:** Please make sure all the information required on this health insurance application has been provided. Best Doctors Insurance Limited reserves the right to contact the applicant if a question has not been answered in detail or if additional information is needed. Any incomplete applications will be returned to the applicant for more information, delaying the processing of your application.

  

**New application**  
Change my current plan/deductible

  

Add spouse/partner/dependents  
Reinstatement

## APPLICANT INFORMATION

LAST NAME(S)

FIRST NAME(S)

STREET ADDRESS

CITY

COUNTRY

EMAIL ADDRESS

TELEPHONE (OFFICE OR MOBILE NUMBER)

FAX

DATE OF BIRTH (MM/DD/YYYY)

HEIGHT

M FT

WEIGHT

KG LB

OCCUPATION

GENDER

Male  
 Female

STATUS

Single  
 Married  
 Widowed  
 Divorced

**Boomers-In-Paradise.org  
Group Policy  
Ajijic, Mexico  
\$5,000.00 USD Deductible**

## DEPENDENT'S INFORMATION

1. FIRST AND LAST NAME(S)	PREMIUM (USD)	<input type="checkbox"/> CRITICAL SELECT	
RELATION TO APPLICANT	DATE OF BIRTH (MM/DD/YYYY)	HEIGHT <input type="text"/> M <input type="text"/> FT	WEIGHT <input type="text"/> KG <input type="text"/> LB GENDER <input type="text"/> M <input type="text"/> F
2. FIRST AND LAST NAME(S)	PREMIUM (USD)	<input type="checkbox"/> CRITICAL SELECT	
RELATION TO APPLICANT	DATE OF BIRTH (MM/DD/YYYY)	HEIGHT <input type="text"/> M <input type="text"/> FT	WEIGHT <input type="text"/> KG <input type="text"/> LB GENDER <input type="text"/> M <input type="text"/> F
3. FIRST AND LAST NAME(S)	PREMIUM (USD)	<input type="checkbox"/> CRITICAL SELECT	
RELATION TO APPLICANT	DATE OF BIRTH (MM/DD/YYYY)	HEIGHT <input type="text"/> M <input type="text"/> FT	WEIGHT <input type="text"/> KG <input type="text"/> LB GENDER <input type="text"/> M <input type="text"/> F
4. FIRST AND LAST NAME(S)	PREMIUM (USD)	<input type="checkbox"/> CRITICAL SELECT	
RELATION TO APPLICANT	DATE OF BIRTH (MM/DD/YYYY)	HEIGHT <input type="text"/> M <input type="text"/> FT	WEIGHT <input type="text"/> KG <input type="text"/> LB GENDER <input type="text"/> M <input type="text"/> F
5. FIRST AND LAST NAME(S)	PREMIUM (USD)	<input type="checkbox"/> CRITICAL SELECT	
RELATION TO APPLICANT	DATE OF BIRTH (MM/DD/YYYY)	HEIGHT <input type="text"/> M <input type="text"/> FT	WEIGHT <input type="text"/> KG <input type="text"/> LB GENDER <input type="text"/> M <input type="text"/> F
APPLICANT (SELF) PREMIUM (USD)			
ADDITIONAL COVERAGE RIDER (USD)			
ANNUAL ADMINISTRATION FEE (USD)		75	
<b>TOTAL (USD)</b>			

## INFORMATION REGARDING ANY OTHER MEDICAL COVERAGE

- Y  N Indicate if you or any of your dependents have any other type of international health insurance. **If YES**, please attach a copy of the plan's certificate of coverage and last payment receipt.
- Y  N Do you intend to continue being insured with the other company?
- Y  N Have you ever had an application for health or life insurance declined or accepted subject to exclusions or at a premium above the insurer's standard rates? **If YES**, please enclose complete information.
- Y  N Have you ever been insured by Best Doctors Insurance Limited or any one of its affiliates? **If YES**, indicate date (MM/DD/YYYY) \_\_\_\_\_  
**If this is a change of plan/deductible**, please indicate previous policy number \_\_\_\_\_

## MEDICAL QUESTIONNAIRE

Answer  Y Yes or  N No to all questions below

**SECTION A:** To the best of your knowledge, have any of the persons listed on this application has or had any of the following conditions during the last ten 10 years **(with the exception of question (a), which must be declared for lifetime)**?:

- Y  N a) Cancer, malignant tumors or benign tumors. **If YES**, indicate type \_\_\_\_\_
- Y  N b) Kidney stones, kidney or bladder problems, urinary frequency or burning
- Y  N c) Goiter, thyroid problems or diabetes
- Y  N d) Epilepsy, paralysis, mental or nervous diseases, alcoholism, migraines
- Y  N e) Drug addiction for which the individual has been treated or hospitalized
- Y  N f) Gall bladder problems, hernia, stomach or intestinal problems, ulcers, hemorrhoids, liver problems
- Y  N g) Cataracts or other eye problems, ear problems
- Y  N h) Tuberculosis, pulmonary diseases, asthma or bronchitis, sinusitis, chronic cough and throat problems
- Y  N i) Arthritis, rheumatism, joint deformation due to arthritis, spine problems, gout
- Y  N j) Heart disease, blood pressure problems, anemia, rheumatic fever, bleeding/clotting disorders of the blood, hemophilia, phlebitis, thrombosis, chest pain, angina, aneurysm
- Y  N k) Female: Menstrual alterations or menstrual hemorrhage, disorders of the reproductive organ, sexually transmitted diseases, breast disorders
- Y  N l) Female: Presently pregnant. **If YES**, indicate date of delivery (MM/DD/YYYY) \_\_\_\_\_
- Y  N m) Female: Indicate number of: Pregnancies: \_\_\_\_\_ Normal Childbirth: \_\_\_\_\_ Caesarean: \_\_\_\_\_  
Abortions: \_\_\_\_\_ Reason for Caesarean: \_\_\_\_\_
- Y  N n) Female: Complications of pregnancy or childbirth, twin pregnancy or a child with any birth defect, congenital disease or hereditary condition
- Y  N o) Male: Prostate problems, sexually transmitted diseases
- Y  N p) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex)
- Y  N q) Dermatitis or skin diseases, skin cancer, or any other skin problem
- Y  N r) Deviated septum, sinusitis, polyps, or other disorders of the noses
- Y  N s) Birth defects and congenital abnormalities, developmental delay, Down syndrome, heart/lung/kidney malformation
- Y  N t) Is any applicant a candidate for or recipient of, an organ, bone marrow or stem cell transplant?
- Y  N u) Is any applicant a candidate for or recipient of, bone/joint pin, screw, nail, wire, plate, prosthesis and/or artificial device?

**SECTION B:** Besides the health problems mentioned in Section A, to the best of your knowledge and understanding is there any person listed on this application who during the last five (5) years:

- Y  N a) Has consulted a doctor or other provider for surgical or medical treatment or for advice regarding another illness not mentioned in Section A?
- Y  N b) Had any health problem or symptom not mentioned in Section A or on Question (a) of this section, for which he/she has or has not consulted doctors?

Y  N c) Have taken or takes any kind of medicine on a regular basis? **If YES**, please state:

NAME OF PATIENT

DIAGNOSIS

TYPE OF MEDICINE AND DAILY DOSAGE

EXPENSE  
PER MONTH

LAST MEDICAL CHECK UP  
(MM/DD/YYYY)

NAME OF YOUR PRIMARY DOCTOR

TELEPHONE OF PRIMARY DOCTOR

ADDRESS OF PRIMARY DOCTOR

Y  N d) Have any of the persons listed on this application lost or gained weight in the last 12 months?  
**If YES**, please state:

NAME

HOW MUCH?

KG  LB

WHAT CAUSED THE CHANGE IN WEIGHT?

**SECTION C:** If you have answered **YES** on any part of Sections A or B please provide complete information in this section and attach the medical report (you may use an additional page if you need more space).

1. NAME OF PATIENT

DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

2. NAME OF PATIENT

DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

3. NAME OF PATIENT

DIAGNOSIS AND TREATMENT

NAME AND ADDRESS OF DOCTOR AND/OR HOSPITAL

DATE (FROM/TO)

**SECTION D:** Please if you have chosen to add the Critical Select Rider, answer truthfully to the following questions:

- Y  N a) Have any of your or your spouse's direct relatives (father, mother, sister or brother) **before the age of 45** been diagnosed or died as a cause of cancer, neurological illness, kidney disease, heart related ailments or any vascular disorders?
- Y  N b) Have any of your or your spouse's direct relatives (father, mother, sister or brother) **before the age of 60** been diagnosed or died as a cause of mental disorders or diabetes?
- Y  N c) Has any relative been diagnosed or died as a cause of multiple sclerosis or any other hereditary sickness or condition?
- Y  N d) Have you smoked at any time within the last 3 years?
- Y  N e) Do you consume alcoholic beverages on a regular basis? If YES, with what frequency:  
\_\_\_\_\_
- Y  N f) Are you currently participating in any dangerous (high risk) activity related either to your job or any recreational activity? If YES, describe the activity  
\_\_\_\_\_
- Y  N h) Do you currently have any medical treatment or clinical consultation scheduled?  
\_\_\_\_\_

**SECTION E:** If you have answered **YES** to any part of Section D, please provide the information asked for in this section and attach the corresponding medical records (you can use an additional paper if needed).

1. RELATION TO PATIENT	DATE (TO/FROM)
DIAGNOSIS AND TREATMENT	
2. RELATION TO PATIENT	DATE (TO/FROM)
DIAGNOSIS AND TREATMENT	
3. RELATION TO PATIENT	DATE (TO/FROM)
DIAGNOSIS AND TREATMENT	

# ACKNOWLEDGEMENT AND AUTHORIZATION

## BY SIGNING OR COMPLETING THE BELOW, IT IS UNDERSTOOD AND AGREED THAT:

- a) Best Doctors Insurance Limited (the Insurance Company) reserves the right to accept or reject your enrollment application. The coverage provided will not become effective until the Insurance Company has received premium payment, completed underwriting, approved the application, and issued the policy. The coverage will become effective on the first or fifteenth day of the month following the date on which the Insurance Company approves the application.
- b) The statements and answers provided are complete, accurate, true, and not misleading according to my best knowledge and understanding (full information). If you have not provided full information on this Application, then the Insurance Company in its sole discretion, without an obligation of reasonableness, may terminate and/or annul the policy issued to you without prior notice.
- c) In the event of a termination as set forth in (b) above, the Insurance Company shall have no obligations of any nature to pay or reimburse any claims originally submitted or due to be submitted pursuant to the policy, subject to a reimbursement by the Insurance Company of any remainder of the policy premium due as calculated pursuant to the early termination provisions of the policy less any amount of benefits paid under the policy prior to this termination for false.
- d) You shall be obligated to refund to the Insurance Company any moneys you received from the Insurance Company for benefits if your policy is terminated or annulled due to failure to provide Full Information and your reimbursement as described in (c) above is not sufficient for the Insurance Company to collect the amounts due.
- e) Upon presentation of a photocopy or original of this signed Application, I authorize any physician, professional, hospital, clinic, or other medical provider, government agency or other person or company to provide the Insurance Company information including copies of records concerning counsel, care or treatment provided to me and/or my dependent(s), without limitation to information concerning mental illness or use of drugs or alcohol.
- f) You and your covered dependents specifically understand and agree that each has elected to allow the agent of record (Agent) to have access to all of the health and medical information (past, present and future) that is ever delivered to the Insurance Company or any one of its affiliates or subcontractors.

### IMPORTANT:

**AS PRODUCER, I ACCEPT FULL RESPONSIBILITY FOR THE SUBMISSION OF THIS APPLICATION AND SENDING ALL THE COLLECTED PREMIUMS. I DO NOT KNOW OF ANY CONDITION THAT HAS NOT BEEN DISCLOSED IN THIS APPLICATION WHICH WILL AFFECT THE INSURABILITY OF THE PROPOSED INSUREDS.**

\_\_\_\_\_  
SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE (MM/DD/YYYY)

\_\_\_\_\_  
AGENT NAME

**BBMXDJ096**

\_\_\_\_\_  
AGENT CODE



**Best Doctors®**

The insurance policy is issued by Best Doctors Insurance Limited, a Bermuda company. Insurance administration services provided by Best Doctors, Inc. on behalf of Best Doctors Insurance Limited.  
[www.bestdoctors-ins.com](http://www.bestdoctors-ins.com)

Call USA Collect  
USA Toll Free Number  
Toll Free Number from Trinidad  
Fax

1305 269 2521  
58 212 771 9274  
1 888 826 9630  
1 800 476 1160