THE CONTOUR GROUP MEDICAL PLAN
ENROLLMENT/CHANGE FORM

PART 1

This form is for:
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family ❑ Late Enrollment ❑ Name Change
❑ Addition of Dependent(s) ❑ Removal of Dependent(s) ❑ Address Change ❑ Beneficiary Change ❑ Termination Notice

Participating Organization:		Group I.D. Number:		
Employee Name: (Last)	(First)		(Middle)	
Occupation:	Citizenship:	❑ Male ❑ Female	Height	Weight
Resident Street Address:		Resident City / State / Country:		
State: Postal Code / Zip Code: Country:		Telephone Number: Email:		
Identification Number / Social Security Number:		Date of Birth:		
REQUESTED EFFECTIVE DATE (DD/MM/YY):		Date Employed Full Time:	Hours Worked Per Week:	
Departure Date from U.S. (if applicable):		Country of Destination:	Length 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 (attach an additional sheet if needed)

Name (Last, First, Middle)		Sex	Date of Birth	Citizenship
Spouse		❑ Male ❑ Female		
Identification Number:	Height:		Weight:	
Name (Last, First, Middle)		Sex	Date of Birth	Citizenship
Child #1		❑ Male ❑ Female		
Identification Number:	Height:		Weight:	
Name (Last, First, Middle)		Sex	Date of Birth	Citizenship
Child #2		❑ Male ❑ Female		
Identification Number:	Height:		Weight:	
Name (Last, First, Middle)		Sex	Date of Birth	Citizenship
Child #3		❑ Male ❑ Female		
Identification Number:	Height:		Weight:	

For dependent children age 19 or older, please indicate name and address of college or university and the number of hours enrolled.

I refuse coverage for : ❑ Myself ❑ Spouse ❑ Children Reason:

I have been given the opportunity to participate in the group insurance plan offered though my employer and I have refused to participate in the coverage as indicated above. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective. **(SIGN HERE ONLY IF REFUSING COVERAGE)**

Signature:_____ Date:_____

Printed Name:_____

PART 2

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 treatment.		
1. Are you or any other applicant currently pregnant, hospitalized, or disabled?	❑ Yes	❑ No
2. Have you ever been diagnosed, treated or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome or any immune system Disorder?	❑ Yes	❑ No
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, or any cardiac, cardiovascular, heart, or circulatory condition?	❑ Yes	❑ No
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	❑ No
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?	❑ Yes	❑ No

PART 3

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 treatment.			
Have you EVER been treated for or been told that you have any illnesses, conditions, medical problems, disorders or other problems relating to any of the following:			
6. Gallbladder, pancreas, or liver?	❑ Yes ❑ No	18. Tumor, cyst, polyp, or growth of any kind?	❑ Yes ❑ No
7. Joints or spine?	❑ Yes ❑ No	19. Sexually Transmitted disease?	❑ Yes ❑ No
8. Eyes, ears, or nose?	❑ Yes ❑ No	20. Heart or circulatory system?	❑ Yes ❑ No
9. Mouth, throat, or jaw?	❑ Yes ❑ No	21. Respiratory system?	❑ Yes ❑ No
10. Chest pain?	❑ Yes ❑ No	22. Nervous system?	❑ Yes ❑ No
11. Headaches, paralysis, or arthritis?	❑ Yes ❑ No	23. Digestive system?	❑ Yes ❑ No
12. Convulsions or epilepsy?	❑ Yes ❑ No	24. Prostate?	❑ Yes ❑ No
13. Elevated cholesterol?	❑ Yes ❑ No	25. Muscular or skeletal system?	❑ Yes ❑ No
14. Cancer or stroke?	❑ Yes ❑ No	26. Reproductive system?	❑ Yes ❑ No
15. Kidney or urinary system?	❑ Yes ❑ No	27. Alcohol or drug dependency?	❑ Yes ❑ No
16. Thyroid, breast, or other glands?	❑ Yes ❑ No	28. Mental health or psychological?	❑ Yes ❑ No
17. Complicated pregnancy or delivery?	❑ Yes ❑ No	29. Diabetes or sugar or blood in urine?	❑ Yes ❑ No

PART 4 Additional Information (Attach additional pages, if necessary.)

Question #	Name	Condition/Diagnosis	Dates of Treatment	Prognosis/Present Course of Treatment	Physician/Facility Name, Address, & Phone Number

PART 5 Beneficiary Information – For each individual applying for life insurance, please indicate:

Beneficiary Name:	❑ Primary ❑ Contingent	Relationship to Employee:	Percent of Death Benefit:
Beneficiary Name:	❑ Primary ❑ Contingent	Relationship to Employee:	Percent of Death Benefit:
Beneficiary Name:	❑ Primary ❑ Contingent	Relationship to Employee:	Percent of Death Benefit:

PART 6 ******MUST BE COMPLETED****

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? ❑ **Yes** ❑ **No**

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:_____Date:_____

Spouse Signature:_____Date:_____