WorldWide Expatriate Association
Benefits Enrollment Information

Benefits are provided through and are underwritten by Capital Life Insurance Company, Limited

1. Applicant Name (Last, First, Middle Initial)	2. Federal ID Number (S.S.N. U.S. Citizens)	3. Sex M/F	4. Birthdate M/D/Y	5. Earnings (specify currency)	6. Country of Citizenship	7. Country of Residency	8. Is U.S. Medicare Primary Coverage Yes or No
				❒Annual ❒Monthly $			
Occupation: (Please describe duties)							

9. Dependents Only list if to be covered — *Relationship codes: W-Wife, D-Daughter, S-Son, H-Husband

Name (First, Middle Initial, Last)	Federal ID Number (S.S.N. U.S. Citizens)	Relation To Employee*	Birthdate M/D/Y	Full-Time Student Yes or No	Country of Citizenship	Country of Residency	Is Medicare Primary Coverage Yes or No

10. Requested Effective Date of Coverage. Must Be first day of any month (For U.S. citizens, this should be the first day of the month in which you are leaving the United States) Actual effective date will be either the Requested date or the date of approval, whichever is later.	Month	Day	Year

11. U.S. address for direct claims correspondence. If you have no U.S. address for this purpose, claims documents will be routed to your international address through WorldWide Expatriate Association, 5910 N. Central Expressway, Suite 1080, Dallas, Texas 75206

Street:

Street:

City:

State/Zip:

12. Beneficiary for Life Insurance: Name (s) (First, Middle Initial, Last)	**Beneficiary Relationship**
Primary:	
Secondary:	

13. Special Remarks

I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

Fraud Warning Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against and insurer, submits a request for enrollment or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I acknowledge that this form is a request for coverage. Coverage will be effective only if and when accepted by Capital Life Insurance Company, Limited and upon payment of all premiums when due.

Applicant
Signature X____ Date Signed____________________

Administrative Use Only

Administrator Signature:	**Date:**
Broker: BHP Buyhealthplan.com	

WorldWide Expatriate Association Evidence of Insurability Statement for Life, Medical and Dental Coverage

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14. Applicant Name (Last, First, Middle Initial	Federal ID Number (S.S.N. U.S. Citizens)

15. Coverages Applied For:

Standard Plan	☐ Applicant	☐ Two Party	☐ Family
Limited Plan	☐ Applicant	☐ Two Party	☐ Family
Optional Dental/Vision:	☐ Applicant	☐ Two Party	☐ Family
In Lieu of $10,000 Life and AD&D	☐ $50,000	☐ 1x Salary	☐ 2x Salary (over $100,000 requires medical exam)

16. Deductible Options: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Applicant: Complete this Section

17. Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed.

Name		Relationship	Date of Birth	Birth Place (City/State)	Sex	Height (ft., in.)	Weight (lbs.)
Applicant:		Self					
Dependent(s):							

Complete these questions if dependent children are listed above. Give dates and details for "No" answers using the space provided in Number 21.

Yes	No	
☐	☐	Do all dependent children live in your household?
☐	☐	Do all dependent children depend on you solely for support?
☐	☐	If any dependent child is age 19 or older, is/are they regularly attending school?

18. Statement of Health for Individual(s) Listed Above. Give complete dates and details for "Yes" answers using the space provided in Number 21.

Yes	No	
☐	☐	Is any individual pregnant?
☐	☐	Are there any inpatient or out patient medical or dental procedures (including diagnostic testing) recommended or contemplated?
☐	☐	Is any individual currently taking medication(s) for any condition? If "Yes", list individual(s), medication and dosage, and indicate duration of use and underlying condition.
☐	☐	Do you use tobacco products? (If the include cigarettes, indicate packs per day___ and number of years smoked___.)

Yes	No	Within the Past	Has any Individual:
☐	☐	5 years	Been examined by, consulted with, or received medical treatment from any physician, dentist or practitioner? If "Yes," please explain.
☐	☐	5 years	Been confined to a hospital, clinic, sanitarium or other medical facility? If "Yes," please explain.
☐	☐	10 years	Been denied life, disability, medical or dental coverage? If "Yes," please explain.
☐	☐	10 years	Been denied group coverage? If "Yes," please explain.

Give complete dates and details for all medical impairments checked using the space provided in Number 21.

Yes	No	
☐	☐	Within the past 10 years, has there been any disease/impairment of or treatment for any individual for any of the following? If "Yes," check the appropriate box(es) below and explain:

☐ AIDS/AIDS Related complex	☐ Cancer	☐ Immune Systems Disorder	☐ Rheumatic Fever
☐ Alcoholism	☐ Carpal Tunnel Syndrome	☐ Intestines	☐ Seizures
☐ Arthritis	☐ Diabetes	☐ Kidney/Bladder	☐ Skin
☐ Asthma	☐ Ears	☐ Liver	☐ Stroke
☐ Back/Spine/Neck	☐ Epilepsy	☐ Lungs	☐ Substance Abuse
☐ Blood pressure	☐ Eyes	☐ Mental/Nervous Disorder	☐ Surgical Operation
☐ Blood Vessels	☐ Gastrointestinal Disorder	☐ Nervous System	☐ Thyroid
☐ Bones	☐ Heart	☐ Paralysis	☐ Tumor Growth
☐ Brain	☐ Hernia	☐ Reproductive System Disorder	☐ Ulcer

19. DENTAL COVERAGE: A recent dental exam (i.e., within the past 12 months) is required before you can be considered for dental coverage.

Yes	No		Yes	No	
☐	☐	Any fillings needed? If "Yes," how many?___	☐	☐	Any teeth need extraction?
☐	☐	Any crowns needed?	☐	☐	Periodontal disease needing treatment?
☐	☐	Any denture/bridgework needed?	☐	☐	Any orthodontic treatment needed?
☐	☐	Missing teeth needing replacement?	☐	☐	Any surgery needed?
☐	☐	Periapical disease (i.e., root canal) needing treatment?	☐	☐	Other ______________________________
☐	☐	Have all individual(s) had a dental exam within the last 12 months? If "No," give details			

	Yes	No	
20.	☐	☐	Does any individual(s) have a known physical impairment(s) or ill health not mentioned in Number 18 and 19**? If "Yes," give complete dates and details.**

21. Use this space to provide the details for **"No" answers in Number 17** and **"Yes" answers** *and/or* **medical impairments checked in Numbers 18-20**. Be specific as to the individual(s) affected. **Indicate the number being answered and provide Names, Dates, Details, Diagnosis and Treatment**.

☐ *Check here if you are providing additional information on a separate attachment.*

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I will inform Wiggins & Company of any material changes to the information provided which take place between the time the form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for coverage and I acknowledged that I have been given a copy of this document as completed by me.

Acknowledgment: I understand that, to the extent permitted by state law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable, I understand that conditions which are disclosed on this form may be subject to all conditions of my plan including any pre-existing condition limitations, employee actively at work and dependent health conditions requirements. I also acknowledge that I am applying for this insurance for my assignment and/or residency outside the United States. My signature indicates that I have reviewed all information and statement on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital service and prepaid health plans, employers and the Medial Information Bureau: You are authorized to provide Wiggins & Company and Capital Life Insurance Company, Limited and their representatives, information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed. I agree that a photographic copy of this authorization is as valid as the original.

Applicant's or Authorized Person's Signature X______________________________ Date Signed ______________

Applicant must sign at all times.

Spouse's or Authorized Person's Signature X______________________________ Date Signed ______________

Spouse must sign when spouse coverage is requested.

Acknowledgement to Administrator (Administrative Use Only)

☐**APPROVED.** Effective ____/____/____.

☐**NOT APPROVED.** For ______________________________. **Applicant has been advised.**

☐ Since the applicant's benefits are not approved, dependent coverage will not be issued.

By: ______________________________ ____/____/____

Date

Administrative Use Only

Administrator Signature:	**Date:**
Broker: BHP Buyhealthplan.com	

WorldWide Expatriate Association Contact Information and Premium Payment Options

Overseas Mailing Address:

Street:
Street:
City:
Country:
Postal Code:
Additional Information:

Overseas Communications:

Home Telephone:	Work Telephone Number:
Home Fax Number:	Work Fax Number:

Other Phone Numbers:

E-Mail Address:
Alternate E-mail Address:

Premium Payment Options:

A check payable to Wiggins & Company for the first months premium or a credit card authorization must be included with this application. We cannot process any applications without the deposit premium. We will cash any checks or process any credit cards until after the policy has been approved.

☐ Monthly Billing ***(Only Available with a US billing Address)***

Billing Contact Name:
Billing Address:

Telephone Number:
Alternate Telephone Number:
Fax Number:
E-mail Address:

☐ Prepayment of annual premium. (Premiums may vary monthly due to coverage changes and/or rate changes). Annual Premium Payments will be due January 1 of each year. If you are signing up for this plan mid year, take the number of months remaining in the year, and that will be your first payment amount.

☐ Prepayment of semi-annual premium. (Premiums may vary monthly due to coverage changes and/or rate changes). Semi-annual Premium Payments will be due January 1 and June 1 of each year. If you are signing up for this plan mid year, take the number of months remaining in the six month period, and that will be your first payment amount.

☐ Please check here if the billing address is the same as your overseas contact address. Otherwise complete below with your billing address for annual or semi-annul premiums.

Billing Name:
Billing Address:

Telephone Number:
Alternate Telephone Number:
Fax Number:
E-mail Address:

☐ Monthly Credit Card Charge. We do accept check credit cards.
5% will be added to any premiums for the use of credit cards.

☐ Visa
☐ Mastercard
☐ American Express
☐ Discover

Credit Card Number:	Expiration Date:

Name as it appears on the card:

Signature as it appears on the card:	X