

Please read through the following, then complete this application in type or block print.

Agency details

414929

All information supplied will be treated in strict confidence. All material facts relating to you and your dependants must be disclosed. Failure to do so may invalidate the coverage. A material fact is one which is likely to influence us in the assessment and acceptance of this application. If you are in any doubt as to whether a fact is material then it should be disclosed.

As the applicant you should answer all questions and sign the declaration on behalf of all persons to be insured. A copy of this application will be supplied to you by us on request. You should keep a record (including copies of all letters) of all information supplied to us for the purpose of entering into this contract.

1. Applicant's details

Requested Commencement Date

MM	DD	YY
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(Must be within 30 days of completion of this application.)

Family Name (s)														
First Name (s)											Other initials			
Gender (Male/Female)				Date of Birth	MM	DD	YY							
Current height (mts or ft)				Current weight (kgs or lbs)										
Nationality				Occupation										

Residential Address (may not be in your country of citizenship)

House name / number												
Road / street name												
Town / City												
State / Province												
Country												
ZIP / Postal code												

Correspondence Address (if different than residential address)

House name / number												
Road / street name												
Town / City												
State / Province												
Country												
ZIP / Postal code												

Contact details

Please indicate your preferred method of us contacting you.

<input type="checkbox"/> Telephone home													<input type="checkbox"/> Telephone business												
<input type="checkbox"/> Fax													<input type="checkbox"/> Mobile												
<input type="checkbox"/> E-mail address																									

2. Dependant(s) details

If there is insufficient space for inclusion of all dependants, please provide details on a separate sheet of paper. Please note that children to be included under this plan must be not more than 18 or 23 years of age if they are in full time education and are fully dependent upon the Applicant.

Dependant 1

Family Name (s)														
First Name (s)											Other initials			
Gender (Male/Female)				Date of Birth	MM	DD	YY							
Relationship to applicant														
Nationality				Occupation										
Current height (mts or ft)				Current weight (kgs or lbs)										

Dependant 2

Family Name (s)														
First Name (s)											Other initials			
Gender (Male/Female)				Date of Birth	MM	DD	YY							
Relationship to applicant														
Nationality				Occupation										
Current height (mts or ft)				Current weight (kgs or lbs)										

Dependant 3

Family Name (s)																									
First Name (s)													Other initials												
Gender (Male/Female)					Date of Birth	MM	DD	YY																	
Relationship to applicant																									
Nationality													Occupation												
Current height (mts or ft)							Current weight (kgs or lbs)																		

3. Medical Questions

Have any of the applicants been diagnosed with or suffered from any of the following conditions:

Conditions

	Yes	No		Yes	No
1) Neurologic conditions, dizziness, fainting, convulsions, paralysis, migraine, impaired vision or hearing or any disease of the brain.	<input type="checkbox"/>	<input type="checkbox"/>	Please also answer the following:	<input type="checkbox"/>	<input type="checkbox"/>
2) Respiratory illness, shortness of breath, asthma, emphysema, sinusitis or any disease of the lungs.	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you under observation or treatment for any medical or dental condition or have any medical /surgical or dental procedures been recommended or are being contemplated?	<input type="checkbox"/>	<input type="checkbox"/>
3) Circulatory, chest pain, murmur, hypertension, arrhythmia, heart attack, high cholesterol or any disease of the heart or blood vessels.	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4) Hepatitis, cirrhosis, ulcers, intestinal bleeding, or any disease of the stomach, intestines, liver, gall bladder or pancreas.	<input type="checkbox"/>	<input type="checkbox"/>	c) Do you use alcoholic beverages? If yes give type quantity and frequency.	<input type="checkbox"/>	<input type="checkbox"/>
5) Arthritis, gout, neuritis or any disease of the bones, muscles or joints including the back or neck.	<input type="checkbox"/>	<input type="checkbox"/>	d) Do you use prescription drugs? If yes, give type, dosage and frequency.	<input type="checkbox"/>	<input type="checkbox"/>
6) Diseases of the eyes, ears, nose or throat.	<input type="checkbox"/>	<input type="checkbox"/>	e) Do you use tobacco products? If cigarettes, please indicate how many per day.	<input type="checkbox"/>	<input type="checkbox"/>
7) Any disease of the kidneys, urinary system, prostate, reproductive organs or breasts.	<input type="checkbox"/>	<input type="checkbox"/>	f) Did you have or are you currently using counselling for alcohol, drug, emotional or mental nervous conditions?	<input type="checkbox"/>	<input type="checkbox"/>
8) Diabetes, thyroid, pituitary, adrenal or other endocrine diseases.	<input type="checkbox"/>	<input type="checkbox"/>	g) Did you have a surgical operation, consultation, diagnostic test or been advised to do so in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
9) Any deformity or amputation.	<input type="checkbox"/>	<input type="checkbox"/>	h) Do you have any family history of heart or circulatory disorders, hypertension or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
10) Cancer, tumor or cyst.	<input type="checkbox"/>	<input type="checkbox"/>	i) Any other disease, injury or defect not mentioned.	<input type="checkbox"/>	<input type="checkbox"/>
11) Acquired Immune Deficiency Syndrome or any AIDS-Related disorders.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
12) Any disease of the skin or lymph glands.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
13) Allergies, anaemia or any other disease of the blood.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
14) Any disorder of menstruation or complication of pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the questions above, please provide details in the additional information box on section 8 of this application; please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/treatment and the names and addresses of attending physicians and medical facilities.

4. Declaration

Acceptance

- I declare that to the best of my knowledge and belief the information given in this application is true and complete. I agree to accept and conform to the terms of coverage when issued, unless I cancel this coverage within 30 days from the commencement date.
- I confirm that I have checked and found correct any answers or statements in this application that are not in my own handwriting.
- I have declared any and all material facts which relate to my application for coverage.

Acknowledgement

I understand that, to the extent permitted by applicable law, false statements may result in denial of claims or my insurance coverage being void as of its commencement date with no benefits payable.

Applicant's Signature

Date

MM	DD	YY
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5. Plan options

This plan enables you to choose various product options to suit your personal requirements. Please clearly tick the benefits options you have selected (Primary Plus or Primary Care) and the deductible option you require. Your coverage will be issued on this basis.

PLAN OPTIONS

Primary Plus

Primary Care

ANNUAL DEDUCTIBLE Please select one of the following Annual Deductibles, this will be the Deductible for all applicants.

\$500*

\$1,000

\$2,500

\$5,000

\$10,000

*Only available with the Primary Plus option

6. Premium Calculation

Using the Global Healthcare Plan Premium Rates Sheet, please complete the premium calculator below. If you require assistance completing this section please call your nearest Goodhealth office.

Payment Mode	Annual <input type="checkbox"/>	Semi-Annual <input type="checkbox"/>	TOTAL
Applicant	\$ Annual Premium +	\$ Semi-Annual Premium +	= \$ Premium Due
Dependant 1	\$ Annual Premium +	OR \$ Semi-Annual Premium +	= \$ Premium Due
Dependant 2	\$ Annual Premium +	\$ Semi-Annual Premium +	= \$ Premium Due
Dependant 3	\$ Annual Premium	\$ Semi-Annual Premium	= \$ Premium Due
			\$ Total Premium Due

7. Premium Payment

Please select your method of payment.

a. Credit Card (annual and semi-annual) American Express Visa Master Card

Card Number

Cardholder's Name

Cardholder's Statement Address

Cardholder's Signature

Date MM DD YY

I authorize Goodhealth Worldwide, until further notice in writing, to charge my credit card account in respect of my premium payments as and when these become due. The Company will inform me in advance of any premium adjustments.

b. Check Payment (annual only) Check Payment All checks must be payable to Goodhealth Worldwide . Please ensure that the name of the Applicant (as declared in section 1 of this form) is clearly stated on the reverse of the check.

c. Bank Transfer (annual only) Please ensure that the name of the Applicant (as declared in Section 1 of this form) is clearly stated on any Bank Transfer

Our Bank details are as follows:

Account Name Goodhealth Worldwide Administrators Inc. **Account Number:** 2000025653579 **ABA Routing:** 063000021
 Premium Trust Account **Denomination:** US Dollar **Swift Code:** PNBPU33

Bank Wachovia Bank
 255 Ponce de León Blvd.
 Coral Gables, FL 33134 USA

Date your Bank was instructed MM DD YY

Please note that your premium will be collected upon receipt of this application which may be in advance of the commencement date.

8. Additional Information

Please list any material facts, for instance but not limited to: hazardous activities, occupational risks, lifestyle risks or any relevant medical details not already stated.

9. Joinder Agreement

The undersigned hereby agrees to the establishment of an Insurance Fund for purposes of implementing an Agreement (the "Agreement") for the Goodhealth Global Health Plan (the "Arrangement"). The undersigned hereby agrees to the designation of Butterfield Trust (Bermuda) Limited as Agent for said Insurance Fund and Agreement. This Joinder Agreement shall be attached to and form a part of said Agreement.

The undersigned, as a Member under the Agreement of 15th November, 2005 accepts and agrees to be bound by the terms of the Agreement, including any amendments thereto.

The undersigned further requests that the insurance coverage indicated in the selected Plan Option be provided for the undersigned individual and dependants (as applicable) under the health insurance policy or policies issued by one of the Underwriters defined in the Agreement, acting through Goodhealth Worldwide (Americas) Limited ("Goodhealth") to the Agent, and (subject to the applicable underwriting requirements of Goodhealth) that such coverage becomes effective as of the requested commencement date indicated in the Goodhealth Global Healthcare Plan Application Form or as of the date of approval by Goodhealth of the undersigned for participation under the Agreement, whichever is later, and continue as long as the undersigned remains a Member.

The insurance benefits provided shall be in accordance with the selected Plan Option and shall be subject to the terms of the health insurance policy or policies issued to the Agent.

Coverage under the Goodhealth Global Healthcare Plan is provided for a 12 month period. A minimum of 12 months of premium is required regardless of the payment option chosen (Semi-Annual or Annual). The undersigned agrees to make the required non-refundable contributions to the Insurance Fund for the insurance coverage requested for undersigned individual and dependants (as applicable). If the undersigned fails to make any required contribution when due, they shall then be liable directly to Goodhealth for such unpaid contributions of the period during which coverage is in force with respect to undersigned individual and dependants (as applicable).

I understand that the insurance policy delivered under the Arrangement is subject to the laws of Bermuda, the jurisdiction in which the Arrangement was established and in which the Agent is domiciled, and Goodhealth and the Agent are not responsible for Member's compliance with applicable local law.

Name	<input type="text"/>		
Signature	<input type="text"/>		
Date Signed	<input type="text" value="MM"/>	<input type="text" value="DD"/>	<input type="text" value="YY"/>

Contact Details for the Goodhealth Worldwide Offices:

Goodhealth Worldwide Administrators Inc.

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*Toll free number for Goodhealth Worldwide (Europe) Limited +800 624 82000 will operate from Belgium, Denmark, France, Germany, Ireland, Israel, Netherlands, Norway, Spain, Sweden, Switzerland and UK. If you are calling from another location please dial +44 (0) 870 442 7376.

**Toll free number for Goodhealth Worldwide (Asia Pacific) Limited +800 624 81000 will operate from Australia, Hong Kong, Japan, New Zealand, Philippines, South Korea and Thailand. If you are calling from another location please dial +852 2104 7486.

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