LLOYD'S

Certain Underwriter at Lloyd's

APPLICATION FOR INSURANCE

Applicant (s) Information

PRIMARY APPLICANT'S INFORMATION:

Name (Last, First, Middle): _____

Mailing Address: _____
Street (Include Apartment Number)

_____ Florida _____ _____
City State Zip

Home Phone: _____ Mobile Phone: _____ E-mail: _____

PERSONAL & DEPENDENT'S INFORMATION:

Last Name, First Name, Middle	Sex:	Date of Birth:	Height:	Weight:	ID Number & Type:
Primary:					

Coverage Information

Requested Effective Date: _____ Deductible Amount: $_____ Plan Name: World*Wide* Plan

	Yes	No
Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who and for how long)	❑	❑

Name: _____ Type: _____ Quantity: _____ How Long: _____
Name: _____ Type: _____ Quantity: _____ How Long: _____

PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE:

Does any applicant **have or ever had** any type of **medical** insurance coverage?. . . . . (if yes, complete chart below):	❑	❑

Applicant's Name:	Company Name:	Policy/Certificate Number:	Effective Date:	Termination Date:

Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.).	❑	❑

Name: _____ Company: _____ Action Taken: _____
Date: _____ Reason for Action: _____

In the last 24 months, has any applicant participated in driving any type of motorcycle?	❑	❑

If yes, which applicant? _____

Medical History (for all applicants- Please provide details of each yes answer in the "Medical History Details" Section)

	Yes	No
1. Are you, or is any family member named in this application, pregnant or an expectant mother or father, or are considering becoming pregnant in the next 12 months?	❑	❑
2. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed?	❑	❑
3. Has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	❑	❑

	Yes	No
4. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❑	❑
5. Has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency problem, or abuse; been advised to reduce alcohol intake; or had any alcohol or drug related moving violation, arrest, or driver's license suspension?	❑	❑
6. Had a complicated pregnancy or delivery (including a caesarean section)?	❑	❑
7. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❑	❑
8. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection; or (c) been diagnosed as having any other sickness or condition derived from an HIV infection?	❑	❑
9. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❑	❑
10. Been confined in a hospital for anything other than childbirth?	❑	❑
11. Had surgery?	❑	❑
12. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❑	❑

Has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:

	Yes	No
13. Digestive System		
a. gallbladder, pancreas, or liver?	❑	❑
b. ulcers?	❑	❑
c. gastroesophageal reflux disease (acid reflux, GERD)?	❑	❑
d. rectal bleeding?	❑	❑
e. other digestive system disorder or condition?	❑	❑
f. esophagus or stomach?	❑	❑
14. Urinary System		
a. kidney?	❑	❑
b. prostate?	❑	❑
c. other urinary system disorder or condition?	❑	❑
15. Brain and Nervous System		
a. migraines or chronic or severe headaches?	❑	❑
b. seizures or epilepsy?	❑	❑
c. mental, emotional, or behavioral disorder (including anorexia or bulimia)?	❑	❑
d. multiple sclerosis or paralysis?	❑	❑
e. other brain or nervous system disorder or condition?	❑	❑
16. Respiratory System		
a. asthma or allergies?	❑	❑
b. sleep apnea?	❑	❑
c. other respiratory system disorder or condition?	❑	❑
17. Mouth, Throat, or Jaw	❑	❑
18. Heart or Circulatory System		
a. chest pain?	❑	❑
b. high or low blood pressure?	❑	❑
d. stroke?	❑	❑
e. shunts, stents, or pacemaker?	❑	❑
f. other heart or circulatory system disorder or condition?	❑	❑
c. elevated cholesterol?	❑	❑
19. Cancer, Cyst, or Tumor		
a. cancer?	❑	❑
b. tumor, cyst, polyp, lump, or growth of any kind? ?	❑	❑
c. basal cell carcinoma?	❑	❑

	Yes	No
20. Blood, Gland, Endocrine, or Metabolic		
a. thyroid, breast, or other glands?	❑	❑
b. diabetes or sugar in the blood or urine?	❑	❑
c. anemia?	❑	❑
d. immune system disorder (other than AIDS or HIV)?	❑	❑
e. other blood, endocrine, or metabolic disorder or condition?	❑	❑
21. Eyes, Ears, Nose		
a. ear or sinus infections (more than two in the past 12 months)?	❑	❑
b. other disorder or condition of the eyes, ears, or nose?	❑	❑
22. Muscular or Skeletal System		
a. joints, bones, spine, or back?	❑	❑
b. arthritis or fibromyalgia?	❑	❑
c. amputation?	❑	❑
d. other muscular/skeletal system disorder or condition?	❑	❑
23. Birth Defects or Congenital Abnormalities		
a. Down's syndrome?	❑	❑
b. cerebral palsy?	❑	❑
c. other birth defect or congenital abnormality?	❑	❑
24. Skin Disorders	❑	❑
25. Male or Female Reproductive System		
a. infertility or erectile dysfunction?	❑	❑
b. sexually transmitted disease?	❑	❑
c. abnormal mammogram or Pap smear?	❑	❑
d. other male or female reproductive system disorder or condition?	❑	❑
26. Has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application?	❑	❑
27. Family History		
Any applicant's family member have a history of:		
a. diabetes, hypertension, or cancer?	❑	❑
b. cardio vascular disorder?	❑	❑
c. congenital or hereditary disease or disorder?	❑	❑

Medical History Details

Question #:	Applicant:	From:	To:
Symptoms or Conditions:			
Prescriptions (include dose, how often taken, dates taken):			
Treatment, Advice Given, Results, and Other Details:			
Name, Address, Phone of Doctor, Hospitals, etc.:			

Medical History Details

Question #:	Applicant:	From:	To:
Symptoms or Conditions:			
Prescriptions (include dose, how often taken, dates taken):			
Treatment, Advice Given, Results, and Other Details:			
Name, Address, Phone of Doctor, Hospitals, etc.:			

Medical History Details

Question #:	Applicant:	From:	To:
Symptoms or Conditions:			
Prescriptions (include dose, how often taken, dates taken):			
Treatment, Advice Given, Results, and Other Details:			
Name, Address, Phone of Doctor, Hospitals, etc.:			

Medical History Details

Question #:	Applicant:	From:	To:
Symptoms or Conditions:			
Prescriptions (include dose, how often taken, dates taken):			
Treatment, Advice Given, Results, and Other Details:			
Name, Address, Phone of Doctor, Hospitals, etc.:			

Medications- Are you currently taking or has it been recommended that you take any medications? (if yes, please indicate below)

Applicant:	Name of Medication:	Reason:
Dosage:	Frequency:	Dates taken (mmyy/mmyy):
Applicant:	Name of Medication:	Reason:
Dosage:	Frequency:	Dates taken (mmyy/mmyy):
Applicant:	Name of Medication:	Reason:
Dosage:	Frequency:	Dates taken (mmyy/mmyy):

Applicant (s) Signature

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

- ✓ This application and the initial payment do not give me immediate coverage
- ✓ I should not terminate existing coverage until I have been accepted by Certain underwriters at Lloyd's.
- ✓ **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**
- ✓ This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.
- ✓ The agent or broker may only submit the application and initial payment, and may not promise me coverage, modify Certain underwriters at Lloyd's underwriting policy or terms of coverage, or change or waive any right or requirement.
- ✓ I must notify Certain underwriters at Lloyd's of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.
- ✓ I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.
- ✓ If Certain underwriters at Lloyd's rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by M.A.M.I. does not constitute approval of my application or create Certain underwriters at Lloyd's coverage.
- ✓ Certain underwriters at Lloyd's may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, Certain underwriters at Lloyd's will determine its payment, and I will be responsible for any difference.
- ✓ Certain underwriters at Lloyd's has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

⇒ X_____ ⇒X_____

Signature of Primary Applicant (You) Signature of Spouse (If to be covered)

Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information

I authorize Certain underwriters at Lloyd's Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company, government agency, consumer-reporting agency, or the Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to Certain underwriters at Lloyd's' Administration and Claims Departments.

Certain underwriters at Lloyd's may also release this information about my family or me to the MIB or any member company. I (we) may request revocation of this authorization by writing to Certain underwriters at Lloyd's. Certain underwriters at Lloyd's may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be re-disclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

Authorization to Obtain and Disclose Health Information

I authorize Certain underwriters at Lloyd's Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health-care provider, consumer-reporting agency, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Certain underwriters at Lloyd's' Administration and Claims Departments. This includes information related to substance use or abuse.

-I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

-Certain underwriters at Lloyd's may release this information about my family or me to the MIB or any member company.

This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

-A photocopy of this authorization is as valid as the original; I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Certain underwriter at Lloyd's; I (we) may request revocation of this authorization; Certain underwriter at Lloyd's may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization; The information that is used or disclosed in accordance with this authorization may be re-disclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information and Authorization to Obtain and Disclose Health Information

⇒ X_____ ⇒X_____

Signature of Primary Applicant (You) Signature of Spouse (If to be covered)

Billing

⇒ X_____ Date: _____

Third Party Notification (in case of nonpayment of premiums)

Name of Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: _____ E-mail: _____

Agent Information

Writing Agent Name: Daniel Feigenbaum Surplus Lines Agent Name: Daniel Feigenbaum

Referring Agent Name: _____ Referring Agent ID Number: _____

Phone: _____ Fax: _____ E-mail: _____

Agent agrees that no material facts have been intentionally omitted and the agent is not aware of any other symptom, condition, or disease not mentioned in this application. Agent acknowledges and agrees that at the time of this application Agent is licensed in the State of Florida, carriers appropriate Errors and Omissions insurance, and is dully registered with M.A.M.I.

⇒ X_____ Date: _____

Signature of Referring Agent

Submission Information

Please e-mail, fax or mail applications to M.A.M.I.:

E-mail:
sales@mamihealth.com
Subject: New Business

Mailing Address:
M.A.M.I.
Attn: New Business
P.O. Box 1650
Hallandale, FL 33008-1650

Fax
US Toll Free 1+866-874-9319 *or internationally 001+561-479-4446*

Customer Service
US Toll Free 1+866-729-1274 *or internationally 001+561-479-4377*

Certain Underwriters at Lloyd's

Policyholder & Market Assistance Lloyd's Market Services

One Lime Street
London
EC3M 7HA

Fax +44 (0)207 327 5225

Telephone: +44 (0)207 327 5693

E-mail: complaints@lloyds.com

This Insurance Product is sold in Florida via Surplus Lines by Certain Underwriters at Lloyd's