For Office Use Only

Quote # _____
Date _____
Status _____

# INSURANCE APPLICATION FORM
## Special Visa Program
### Silver Plan (ACA Compliant)

Use this Application Form to apply for coverage under the Silver Plan (ACA compliant). Please fill out this form completely (incomplete forms will cause a delay in processing). The person to be covered must have a valid G Visa or A Visa (for example, G5, G4, A3, or another type of G or A Visa).

Coverage begins on the later of November 1, 2016 or the first day of the month following the date you submit this Application Form and Bank Authorization Form, provided your application is approved by WellAway, Ltd.

### Enrollment Deadline

The Open Enrollment Period is the only time of the year in which you can buy the Silver (ACA) Plan, unless you or your Dependent qualifies for a Special Enrollment. During the Open Enrollment period, the policy will provide an opportunity to all eligible persons to enroll in the Silver (ACA) Plan without individual underwriting or imposition of waiting periods, exclusions or limitations for pre-existing conditions. Special enrollment is allowed in some situations: for certain individuals who lose coverage, or for a newly acquired spouse or other eligible Dependents – for instance, through marriage, birth or adoption. For full details of the eligibility requirements, please refer to the Policy Terms and Conditions. The Open Enrollment Period starts on November 1, 2016 and ends at midnight on March 31, 2017.

Mail or email this form along with a copy of the applicant/insured's Visa and dependent(s)' Visa to:

Safe Passage International, LLC
3609 S. Wadsworth Blvd., Suite 565, Lakewood, CO 80235
Tel: 303-988-9626 x117, or Toll Free: 1-800-777-7665 x117
Fax: 720-504-3735 Email: Visa@spibrokers.com
Website: www.spibrokers.com/Visa

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# Silver Plan (ACA) Application

*If you need assistance in completing this form, please contact Safe Passage International at 303-988-9626 x117 or Toll Free 1-800-777-7665 x117*

## Policyholder Details

*Requested coverage start date : / /*

| | | | | | |
|---|---|---|---|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Miss | | | | |
| First Name: | | Middle Name: | | Last Name: | |
| Gender: | ☐ Male ☐ Female | Nationality: | | Date of Birth: | |
| Social Security Number (S.S.N) : | | | | Smoker: | ☐ Yes ☐ No |
| Visa Type: | | Country of Origin: | | | |

### *Contact Details*

| | | | |
|---|---|---|---|
| Phone *(Main)*: | | Phone *(Work)*: | |
| E-mail: | | Fax *(Optional)*: | |

| | |
|---|---|
| Do you currently have health coverage with any other insurer? If yes, which insurer? | ☐ Yes ☐ No |
| | |

## Policyholder Addresses

**Permanent in Country of Origin** - *This is the address where you are residing in your country of origin.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Address 1: | | | | | | |
| Address 2: | | | | | | |
| Town/City: | | State: | | Zip Code: | Country: | |

**Destination Address -** *This is the address where you will be residing abroad.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Address 1: | | | | | | |
| Address 2: | | | | | | |
| Town/City: | | State: | | Zip Code: | Country: | |

**Billing Address -** *If different from above.*

| | | | | | | |
|---|---|---|---|---|---|---|
| Address 1: | | | | | | |
| Address 2: | | | | | | |
| Town/City: | | State: | | Zip Code: | Country: | |

## Spouse

| | | | | | |
|---|---|---|---|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Miss | | | Visa Type: | |
| First Name: | | Middle Name: | | Last Name: | |
| Gender: | ☐ Male ☐ Female | Nationality: | | Date of Birth: | |
| E-mail: | | S.S.N: | | Phone: | |
| Occupation: | | Employment Status: | | Smoker: | ☐ Yes ☐ No |

## Dependents

### Dependent 1

| | | | | | |
|---|---|---|---|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Miss | | | Visa Type: | |
| First Name: | | Middle Name: | | Last Name: | |
| Gender: | ☐ Male ☐ Female | Nationality: | | Date of Birth: | |
| E-mail: | | S.S.N: | | Smoker: | ☐ Yes ☐ No |
| Status: | ☐ Student | ☐ Employed | ☐ Self-employed | ☐ Unemployed | |

### Dependent 2

| | | | | | |
|---|---|---|---|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Miss | | | Visa Type: | |
| First Name: | | Middle Name: | | Last Name: | |
| Gender: | ☐ Male ☐ Female | Nationality: | | Date of Birth: | |
| E-mail: | | S.S.N: | | Smoker: | ☐ Yes ☐ No |
| Status: | ☐ Student | ☐ Employed | ☐ Self-employed | ☐ Unemployed | |

### Dependent 3

| | | | | | |
|---|---|---|---|---|---|
| Title: | ☐ Mr ☐ Mrs ☐ Miss | | | Visa Type: | |
| First Name: | | Middle Name: | | Last Name: | |
| Gender: | ☐ Male ☐ Female | Nationality: | | Date of Birth: | |
| E-mail: | | S.S.N: | | Smoker: | ☐ Yes ☐ No |
| Status: | ☐ Student | ☐ Employed | ☐ Self-employed | ☐ Unemployed | |

Additional Dependent Address - If any of the above dependents reside at a separate address, please complete the section below.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dependant: | ☐ Spouse | ☐ Dependent 1 | ☐ Dependant 2 | ☐ Dependant 3 | | | |
| Address 1: | | | | | | | |
| Address 2: | | | | | | | |
| Town/City: | | State : | | Zip Code: | | Country: | |

## Agreement

Review the completed application and read the section below carefully before signing

## Statement of Understanding

1. I personally completed this application and confirm that the answers and statements on it are true, complete, and accurate. I understand that:
2. This application and the initial payment do not give me immediate coverage.
3. Coverage is dependent on the approval of my WellAway Application.
4. My WellAway coverage start date must be 3 or more days from the application enrollment date.
5. The coverage will begin once your application has been approved and your first premium has been paid.
6. The coverage start date will be on the first day of the following month from when the application was approved.
7. I should not terminate existing coverage until I have accepted the WellAway, Ltd. coverage.
8. Intentionally fraudulent or incomplete information on this application may result in voidance of coverage and claim denial.
9. This completed application, and any supplements or amendments will be a part of any policy/certificate, if issued.
10. The broker may only submit the application and initial payment, and may not promise me coverage, modify WellAway, Ltd.'s underwriting policy or terms of coverage, or change or waive any right or requirement.
11. 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.
12. If WellAway, Ltd. rejects this application, under no circumstances will any benefits be payable. Receipt of money, or debiting my bank account by or on behalf of WellAway, Ltd does not constitute approval of my application or create coverage.
13. The policy requires some medical services to be authorized by WellAway, Ltd. or its representative before the services are provided, and benefits for these services may be reduced if the prior authorization is not obtained.

## Authorization to Obtain and Disclose Nonmedical Information

I authorize WellAway, Ltd. to obtain information that they need to verify my application for insurance. I authorize WellAway, Ltd to share this information with any of its representatives or partners involved in providing the services and coverage agreed upon. Any employer, insurance company, government agency, or consumer-reporting agency 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 WellAway, Ltd.. This authorization shall remain valid until the termination of coverage.

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 WellAway, Ltd.

I (we) may request revocation of this authorization by writing to WellAway, Ltd. WellAway, Ltd. 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 disclosed by the receiving entity and may no longer be protected by federal or state privacy law.

I agree that in the event of any controversy or dispute between WellAway Ltd and I and my dependents must exhaust the appeal and/or grievance processes outlined in the benefit/member Policy Terms and Conditions issued to me. I acknowledge that WellAway Ltd.'s coverage is contingent upon the complete, accurate disclosure of the information requested on this form. I understand and agree that misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

Policy Holder X_____ Date: _____

# Payment Authorization
# Silver Plan (ACA)

Use this Authorization Agreement to initiate recurring automatic deductions from your bank account to pay the monthly cost of the Silver Plan (ACA). You can also pay your premium by check or money order. Credit card payments are not accepted.

Please fill out this form completely. Mail or email the completed form to:

Safe Passage International, LLC
3609 S. Wadsworth Blvd., Suite 565, Lakewood, CO 80235
Tel: 303-988-9626 x117, or Toll Free: 1-800-777-7665 x117
Fax: 720-504-3735 Email: Visa@spibrokers.com
Website: www.spibrokers.com/Visa

(Please type or print legibly)

Employer/Sponsor

_____

First M. Last

Applicant/Insured _____

First M. Last

I (we) hereby authorize Safe Passage International, LLC, hereinafter called the Program Manager, on behalf of WellAway, Ltd., to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit to my (our) bank account as indicated below, hereinafter called the Originating Bank, to credit and/or debit the same to such account.

Originating Bank Name: _____

City _____

Zip Code _____

Routing/ABA # _____

Account # _____ Account Type: Checking ❑ Savings ❑

This Authority shall remain in full force and effect until the Administrator has received written notification from me (or either of us) to its termination in such time and in such manner as to afford the Administrator and Originating Bank a reasonable opportunity to act on it.

Bank Account Owner's Name: _____
(Please Print)

Owner's Signature: _____ Date: _____