BUPA CORPORATE CARE APPLICATION FOR GROUP HEALTH INSURANCE

Please complete this form and return it to Bupa with the following:

- Company/Organization Registration Certificate
- Payroll listing of all employees, even if all are not to be covered
- A completed Member Enrollment Form for each member (for Community Rated groups only)
- A completed Medical Supplement for each member (for Community Rated groups only)
- Claims history from previous insurer for the last two years of claims (for Experience Rated groups only)

SECTION 1

A. Group Type
Please select a group according to the amount of members:

☐ Community Rated (for groups of 10 – 69 members)
☐ Experience Rated (for groups of 70+ members)

B. Option and Plan
Please select the desired area of coverage and deductible to apply to all members:

Maximum annual coverage Area of coverage	☐ Option 1 US$1,000,000 Worldwide (excluding USA)	☐ Option 2 US$2,000,000 Worldwide (including USA)

cvbcvb	☐ Plan 1	☐ Plan 2	☐ Plan 3	☐ Plan 4
Worldwide Deductible	US$0	US$500	US$2,000	US$10,000
USA Deductible	US$1,000	US$2,000	US$5,000	US$10,000

Please select any riders for additional coverage requested: ☐ Dental Care ☐ Vision Care

SECTION 2

A. Group Administrator's Information

Company/Organization name (to be displayed on invoices and documents)					
Type of business (standard industry classification)					
Business address					
City		State		Country	
Tel number		Fax number			
E-mail		Website			
Mailing address (if different than above)					
City		State		Country	
Group Administrator's name					
Tel number		E-mail			

Who should receive your members' insurance documents? ☐ Group Administrator ☐ Producer

B. Previous Coverage (If applicable)

Is the group currently covered by another insurance plan? ☐ Yes ☐ No

If the answer is "yes", please provide the following:

Name of current insurer			
Effective date of coverage under the existing plan	MM / DD / YY	Date coverage will terminate in the existing plan	MM / DD / YY

Reason for terminating coverage with the existing plan	
Will the existing plan continue in force if the Bupa Corporate Care policy is approved? ☐ Yes ☐ No	

C. Eligibility

No. of members to join now		No. of dependents to join now	
Requested effective date of coverage	MM / DD / YY	How many Member Enrollment Forms are being submitted with this Application?	

Name and address of any subsidiary or affiliated companies/organizations to be covered (please include additional page if needed):

Company/Organization name (to be displayed on invoices and documents)					
Type of business (standard industry classification)					
Business address					
City		State		Country	
Tel number		Fax number			
E-mail		Website			
Mailing address (if different than above)					
City		State		Country	

SECTION 3

A. Billing Options

Select billing frequency: ☐ Annual ☐ Semi-annual

Select method of payment: ☐ Check ☐ Wire transfer ☐ Credit Card (Please attach Credit Card Authorization Form)

Note: Payment must be made by the **Group Administrator** in US dollars. No individual payments from members or dependents will be accepted.

SECTION 4

A. Administration and Declaration (to be completed by the Group Administrator or authorized representative)

As Group Administrator or authorized representative, I hereby declare that the business I represent employs _____ members or full time employees (30 hours or more per week) and that no-part-time employees have been included for coverage.

I have answered all statements in completeness and truth to the best of my knowledge and belief. I understand that Bupa Insurance Company will rely on the statements in this Application as the basis for any policy issued. Any omissions or incorrect or incomplete statements may result in the denial of a claim, the modification of the contract, or the rescission of the insurance policy pursuant to the terms and conditions of the policy. No information will be considered as having being provided to Bupa Insurance Company, unless it is included in this Application.

No waiver or modification of a contract provision or of any of the Group's rights or requirements shall be binding upon the Group unless it is in writing signed by an accredited officer of Bupa Insurance Company.

I agree to provide written notice to Bupa Insurance Company of any new member joining the firm or an existing member no longer eligible for coverage within 30 days from the date he/she becomes eligible for coverage, or when he/she terminates full time employment, or is otherwise not eligible for this coverage.

I hereby represent that the group health plan for which this insurance is being purchased is not subject to the Employee Retirement Income Security Act (ERISA) of 1974 as amended, and is not required to offer continuation of coverage pursuant to U.S. federal "COBRA" laws. I will notify Bupa Insurance Company immediately if either of the foregoing representations cease to be true.

B. Group Administrator or Authorized Representative

Name		Title	
Signature		Date	MM / DD / YY
Producer's name		Code	
Producer's signature		Date	MM / DD / YY

Note: Insurance coverage is not effective until written approval is issued by Bupa Insurance Company. Insurance coverage will become effective on the date specified by Bupa Insurance Company, and this may vary from the effective date requested. Do not cancel any existing coverage until coverage under this plan is approved.