GROUP INTERNATIONAL MAJOR MEDICAL PLANS

An International Major Medical Series Plan

FOR

Foreign Nationals while Visiting the U.S.A.

U.S.A. Citizens Residing or Traveling outside the U.S.A.

Foreign Nationals who reside outside the U.S.A. and who work for a U.S.A. Firm

USES

Business Assignments

Pleasure

Educational Pursuits

Religious Activities

PLANS AVAILABLE FOR

Short Term

Multiple Trips

Long Term

GIC Insurance Agency
P.O. Box 291 Fair Grove, Missouri 65648
Phone:(417) 759-2009 • Fax: (417) 459-4870
www.gicinsurance.com • info@gicinsurance.com

PROPOSAL REQUEST/APPLICATION

GIC Insurance Agency
P.O. Box 291 Fair Grove, Missouri 65648
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PART I. General

Full Name of Company or Group: ______________________

Type of Company: ______________________

Address: ______________________

Contact Person: ______________________ Title: ______________________

Phone: ______________ Fax: ______________ E-Mail: ______________

Target Effective Date: ______________ Is coverage to be: On-going? ❑ or Fixed time period? ❑

If fixed, length of cover needed: ______________________

Does this group have current coverage or had prior coverage? YES ❑ NO ❑

If Yes please indicate for at least past three years: Name of Carrier: ______________________

Reason for changing: ______________________ Please attach Loss data as detailed as possible

Full-Time People: Total in Group: ______________ Total to be covered under this plan: ______________

Part-time People: Total in Group: ______________ Total to be covered under this plan: ______________

Number of people to be covered by age band: Under 30 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60-64 ____ 65+ ____

Should this proposal include an option for dependents? YES ❑ NO ❑

Should this proposal include cover in the USA? YES ❑ NO ❑

A census of the group to be covered, including names, addresses, and dates of birth will be needed during final underwriting.

Will this be: ❑ Voluntary or ❑ Non-voluntary

If you could design your own plan, what benefits would you include?:

Deductible: $ ________ Co-insurance: ________ Maximum benefit: $ ________ Target Monthly Premium: $ ________

Other Requests?: ______________________

Other Thoughts or Comments?: ______________________

Rate and plan design guarantees, premium billings, and addition of new employees are subject to change from group to group. These items will be provided with a proposal. Contract disputes are required to go before binding arbitration. If you already have a proposal, please attach a copy of the plan desired for final underwriting approval. Once received, this application and information shall be reviewed and full market support will be sought. Coverage cannot be bound until there is 100% market support. Completion of this Proposal/Application does not constitute an offer or acceptance.

Signature of Company/Group Representative: ______________________ **Date:** ____________

Printed Name and Title: ______________________

GROUP INTERNATIONAL MAJOR MEDICAL PLANS

The following is a description of a standard basic plan design. Alternative designs are available on a case by case basis. Each plan is designed to best fit the size and needs of the group. In some cases, provisions of the following description may be enhanced or deleted.

DESCRIPTION OF TYPICAL BENEFITS

DEDUCTIBLE	COINSURANCE	MAXIMUM BENEFIT
Choice of **$100, $250, $500, $1,000, $2,500 or Higher** per illness or injury	After the deductible Underwriters will reimburse **80%** of next $5,000 in eligible expenses and **then 100%** up to the Maximum Benefit	**$25,000 - $5,000,000**

Eligible expenses caused by an illness or injury and incurred from any doctor or any hospital within a specified geographical area will be reimbursed to you. Benefits may be assignable directly to the providers once a Claim Review has been completed.

ELIGIBLE EXPENSES

Hospital Expenses including:

Semi-private room and board, intensive care, other medically necessary hospital services and supplies, such as emergency room care, outpatient surgery, diagnostic services, supplies and therapy.

Physician Services Consisting of:

Home, office, and hospital visits, diagnostic services, supplies and therapy.

Skilled Nursing Facility including:

Room and board, provided confinement begins within 30 days following a medically necessary hospital confinement of three days or longer.

Home Health Care:

If hospitalization would have been required if Home Health Care were not provided, and the Home health Care is provided in accordance with a written plan established and approved by a physician.

Ambulance Services:

To and from a hospital in the geographic area.

Prescription Drugs:

Covered during and following a period of hospitalization.

Repatriation of Remains:

In the case of death, underwriters will reimburse the costs of delivery of your remains to a mortuary near your home.

Common Accident Provision:

In the event that you and any additional insured family members suffer injuries from the same accident, only one deductible and coinsurance shall be applied.

Global Medical Transportation Coverage:

Underwriters will reimburse you for the costs of medically necessary transportation to return you to the facility nearest your home which can provide appropriate care, up to $100,000.

This is not intended to be a complete outline of coverage.
Actual wording may change without notice.

GROUP INTERNATIONAL MAJOR MEDICAL PLANS

The following is a description of a standard basic plan design.
Alternative designs are available on a case by case basis.

LIMITATIONS

Expenses which have limitations are as follows: .

1) The maximum Eligible Expense for room and board charges is $450 per day.
2) The maximum Eligible Expense room and board charge for an intensive care unit is three times the Provider's semi-private room and board charge or $1350 per day whichever is the least.
3) Insured age 70-74 are limited to $250,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
4) Insured age 75-79 are limited to $100,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.
5) Insured age 80-84 are limited to $50,000.00 maximum benefit or as shown on the Schedule of benefits page, whichever is the least. All other terms and conditions apply.

A Preexisting Condition will not be covered until the insurance described in this certificate has been in effect for a period of 12 months. A preexisting condition is one in which an insured sought medical attention or was advised to seek medical attention during the 12 month period preceding the effective date of the policy.

Expenses which are not eligible for reimbursement are as follows:

1) Any expense which You are not legally obligated to pay.
2) Services which are not Medically Necessary or are not furnished by and under supervision of a Physician .
3) Expenses for services and supplies for which You are entitled to benefits, services or reimbursement through the Veterans' Administration, Workers' Compensation insurance, any private health plan or from any other source except Medicaid.
4) Expenses in excess of UCR.
5) Outpatient drugs, except following a hospitalization if prescribed for the same Illness or Injury.
6) Self-inflicted injuries while sane or insane.
7) Treatment for alcoholism, drug addiction, allergies
8) Mental or nervous disorders.
9) Rest cures, quarantine or isolation.
10) Cosmetic surgery unless necessitated by an injury.
11) Dental exams, dental x-rays and general dental care except as a result of an injury.
12) Eye glasses or eye examinations.
13) Hearing aids or hearing examinations.
14) General or routine examinations.
15) Injuries sustained from participation in Hazardous Sports or Activities
16) Pregnancy and pregnancy-related conditions including but not limited to fertility, pre-natal care, childbirth, miscarriage, abortion or postpartum conditions.
17) Injuries or illnesses due to war or any act of war whether declared or undeclared.
18) Injuries or illnesses sustained while committing a criminal or felonious act.
19) Expenses incurred for or resulting from pain which is not supported by medical diagnosis.
20) Cataract surgery
21) Any elective surgery.
22) Custodial Care.
23) Expenses for supplies and services that were not incurred within the specified Geographic Area.
24) Pre-existing conditions.

This is not intended to be a complete outline of coverage. Actual wording may change without notice.
Underwriters reserve the right to modify terms and benefits at time of underwriting.

PETERSEN INTERNATIONAL UNDERWRITERS
23929 Valencia Boulevard, Suite 215, Valencia, California 91355
(661) 254-0006 (800) 345-8816 Facsimile (661) 254-0604
Website: http://www.piu.org E-Mail: piu@piu.org

AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION
This Authorization complies with the HIPAA Privacy Rule

I, ___________________________________ hereby acknowledge this Authorization to Release Health
(Proposed Insured/Patient)
Related information.

I authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment which includes, but is not limited to:

Physicians
Hospitals
Clinics
Medically related facilities
Rehabilitation facilities
Laboratories
Other/Specific: ____

____ Proposed Insured/Patient Initials

to disclose my medical records to Petersen International Underwriters (or its assigned representative including, but not limited to: Secure Image Solutions) for the purpose of insurance underwriting or claims administration. For purposes of this authorization, medical records shall include, but not be limited to:

Patient Histories
Progress notes
Test results
X-rays
Psychiatric Evaluations
Drug and/or Alcohol Treatment information
HIV Test Results and/or
Other diagnostic information

____ Proposed Insured/Patient Initials

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

____ _____________________
Signature of Proposed Insured/Patient Date

____
Printed Name

____ _____________________
Signature (if by someone other than the Proposed Insured/Patient) Date

____
Printed Name and Relationship

I, ____________________________ understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above.

I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to:

Petersen International Underwriters
23929 Valencia Boulevard, Suite 215
Valencia, California 91355

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization.

This Authorization will expire 2 years after the date the Authorization is signed unless a different date is specified here: ___________________.

If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.

____ ____________________
Signature of Proposed Insured/Patient Date

____
Printed Name

____ ____________________
Signature (if by someone other than the Proposed Insured/Patient) Date

____
Printed Name and Relationship

Petersen International Underwriters
Privacy Policy Statement

Petersen International Underwriters

Petersen International Underwriters want you to understand how we protect the confidentiality of non-public personal information we collected about you.

Information We Collect

We collect non-public information about you from numerous sources including, but not limited to:

a) Information we receive from you on applications and other forms;
b) Information about your transactions with our affiliates, others or us;
c) Information we receive from consumer-reporting agencies; and
d) Financial and medical sources.

Information We Disclose

We do not disclose any non-public information about you to anyone except as is necessary in order to provide our products or services to you or otherwise as we are required or permitted by law (e.g. subpoena, fraud investigation, regulatory reporting, etc.).

Confidentiality and Security

We restrict access to non-public personal information about you to our employees, our affiliates' employees or others who need to know that information to service your account. We maintain physical, electronic and procedural safeguards to protect your non-public personal information.

Contacting Us

If you have any further questions about this privacy statement or would like to learn more about how we protect your privacy, please contact the insurance producer who handled this case, or our offices at: 23929 Valencia Boulevard, Suite 215, Valencia, California 91355, (800)345-8816, e-mail: piu@piu.org