

HTH Worldwide Health Plan Pre-Screening Form Instructions

HTH Worldwide

Thank you for submitting a Pre-Screening Form to HTH Worldwide.

- HTH Worldwide Health Plans are specially designed for members of the Global Citizens Association.

Instructions

Do not complete this Pre-screening form until you have read the current product brochure or website.

Please follow these instructions to allow us to better process your form.

- **For your own protection you must complete this form. You are solely responsible for its accuracy and completeness.**
- All information must be stated accurately.
- All questions must be answered in full or the form may be returned to you resulting in a delay in processing.
- For additional information or explanations, attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink. No correction fluid, please. **Sorry, typed forms will not be accepted.**
- This form must be received by HTH Worldwide within thirty (30) days from the signature date.
- Even if the subsequent application is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.

Payment Information

Most common causes for delay in processing

- Missing, inaccurate or incomplete information such as:
 - Weight AND Height
 - Spouse's social security, visa, or passport number
 - Dependent's social security, visa, or passport number
 - Date of birth
 - Date of last pelvic examination
 - Results of last pelvic examination
 - Physician's address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city, state and Zip Code.
- ALL questions are not answered in Sections 3 and 5. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The form is not signed and dated by all individuals and/or all dependents over age 18.
- Additional documentation or information is required.

Mailing Address

- **Applicant:** Please return this form to the address below or to your agent.

HTH Worldwide
Attn: Individual Underwriting Department
100 Matsonford Road
Suite 100
Radnor, PA 19087

Faxing a form

- To expedite processing, please fax to 1.610.672.9635.
- HTH Worldwide must be in receipt of original document. After faxing the form, please mail original form to your agent or to the mailing address listed above.

HTH Worldwide Health Plan Pre-Screening Form

Form must be completed by the individual in blue or black ink.

Social Security No.	
Visa/ Passport No.	
Agent I.D. No.	24874

1. Individual's Information (Please Print)

Primary Individual's Last Name	First Name	M.I.
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Address Outside the US

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	Postal Code	Country	

Address Inside the US

Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	State	Zip Code	

Mailing Address (In Care Of)

In Care Of:			
Street	Apt No.	(P.O. Box or Personal Mail Box No.)	
City	State	Postal Code	Country

Home Phone No. ()	Daytime Phone No. ()	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Business Phone No. ()	Fax No. ()	Spouse's Social Security/ Visa/ Passport No.
Email Address	Maiden Name of Individual/Spouse (If applicable)	

2. Plan of Interest- Please enter plan name and deductible option

Prescription Drug Rider (only available on Global Citizen plans)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dental Rider (Global Citizen Elite Plans only)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

3. Personal Details

Please list all people interested in coverage. (List children youngest to oldest)
If a family member's last name is different than yours, please attach explanation to this form.

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security/ Visa/ Passport No.
				Height	Weight		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself						
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							

How did you hear about HTH Worldwide? _____
 How much time in the next 24 months will you be outside of your home country? _____
 What locations? _____

Social Security No.

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Visa/ Passport No.

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3. Personal Details continued

Applies to couples or families:

If you are married or have children, will all family members be applying for coverage? Yes No N/A

If No, Why? _____

Are you a U.S. Citizen? Yes No Are you a foreign national residing legally in the U.S.? Yes No

Please list your occupation and duties.

Please provide the name of your employer.

Please provide your employers address.

4. Other Coverage - Please answer all of the following questions.

A. Do you currently have or has anyone had coverage in the last 18 months? Yes No

If Yes, please provide the following information.

Name of insured(s)	Insurance carrier(s)	Effective date	End date

Do you agree to discontinue your current coverage if accepted? Yes No

If No, please explain:

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B. Has anyone identified on this form ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

C. Are any persons on this form eligible for Medicare or Medicaid benefits? Yes No

If Yes, please list all eligible person(s). Note: Anyone eligible for Medicare Part A or B is **not** eligible for Global Citizen or Global Navigator but may be eligible for Global Citizen EXP.

Eligible person(s)

D. Has anyone on this form filed a claim for disability or Workers' Compensation within the past 18 months? Yes No

If Yes, please provide the following information.

Name of applicant	Effective date	End date

Social Security No.									
Visa/ Passport No.									

6. Conditions of Pre-Screening

It is important that you carefully read and fully understand the following.

All individuals age 18 and over must personally read, agree to, and sign the following. If an individual does not read English, the translator must sign and submit the Statement of Accountability, Section 7, for translating the entire form.

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this form.

Agreement (All individuals listed on form)

I, the undersigned, agree to the following:

PLEASE NOTE: If the listed minor dependent does not reside with the individual completing this form, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Pre-Screening Form, accepting legal responsibility for full and complete disclosure of the minor, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.

1. I understand that this form is not an application. An application form must be completed in order to secure coverage.
2. MINOR CHILDREN: I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this form regarding minor children.
3. CONCERNING DEPENDENTS AGE 18 AND OVER: I represent that my dependents age 18 and over (1) have read this form and have provided such full and accurate information necessary to complete this form, (2) I have discussed all provisions of this form, especially Sections 5A, 5B, 5C and 5D with them and (3) all information is complete and accurate.
4. HTH Worldwide may request additional information, and this may delay processing of this form. If the health care provider charges a fee for these services, HTH Worldwide will determine payment, and I will be responsible for any difference.
5. The selling agent has no authority to promise me coverage or to modify underwriting policy or terms of any HTH Worldwide Health Plan.
6. I have personally read and completed this form. Nothing has been left off regarding the past or present health of anyone listed on this form. I understand that no one listed is eligible for benefits if any information on this form is false, incomplete, or omitted. If future application is accepted, HTH Worldwide may void all coverage from the original effective date of agreement for such material intentional misstatements or omissions.

Yes. I Agree

Signature

FRAUD NOTICE Please read carefully

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Arkansas Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida 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.

Kentucky Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

New Jersey Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Tennessee It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Authorization/Disclosure Statement

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide HTH Worldwide's authorized underwriters or Medical Directors, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders (other than psychotherapy notes), AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of a pre-screening form for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through thirty (30) months. A photocopy of this Authorization is as valid as the original. My authorized representative, or I am entitled to receive a copy of this form. I understand any request for psychotherapy notes will require separate authorization.

I understand and agree to all the Conditions of this pre-screening form (Section 6). I have read and understand this form in its entirety. I certify that I have received an outline of coverage. I understand that this form is not an application for coverage, but a pre-screening form.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse (required if applying for coverage)	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

Notice of Information Practices

If you apply for or are covered by an HTH Worldwide health care plan, HTH Worldwide may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, HTH Worldwide may provide information to a hospital in order to verify benefits. Upon your request, HTH Worldwide will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. HTH Worldwide can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

7. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

Applicant does not read English

Applicant does not speak English

Applicant does not write English

Other (*explain*): _____

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the “Conditions of Pre-Screening (Section 6).”

By **X** _____

Insurance coverage is underwritten by an outstanding U.S. Admitted Company—BCS Insurance Company, rated A- (Excellent) by A.M. Best for financial strength. BCS Insurance Company, known for innovative product development and special risk underwriting, is based in Oakbrook Terrace, Illinois.

To find out more about BCS, visit <http://www.bcsigroup.com/plan/about/introduction.html>