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is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.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.

Social Security No.

Visa/ Passport No.

Agent I.D. No. 141622

HTH Worldwide

HTH Worldwide Health Plan Pre-Screening Form

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

1. Individual's Information (Please Print)

Primary Individual's Last Name	First Name	M.I.

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 ❑ Single ❑ 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)	❑ Yes	❑ No
Dental Rider (Global Citizen Elite Plans only)	❑ Yes	❑ 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 Height	Weight	Date of Birth	Social Security/ Visa/ Passport No.
❑ Male ❑ Female	Yourself				
❑ Husband ❑ Wife	Spouse				
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ Daughter					
❑ Son ❑ 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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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:

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.

5. Health History – Include information on all family members.

5A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE FORM MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 5A, you must give complete details in Section 5B.

Has any person listed on this form received medical advice, diagnosis or treatment, or had treatment or consultation recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **within the last 10 years?**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis or any other neurological or central nervous system disorder(s) ❑ Yes ❑ No
2. Dizziness, weakness, fainting, numbness/ tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy or any similar symptoms ❑ Yes ❑ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ❑ Yes ❑ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever or any other circulatory condition ❑ Yes ❑ No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition ❑ Yes ❑ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring or use of a sleep monitoring device ❑ Yes ❑ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ (Temporomandibular Joint Dysfunction) ❑ Yes ❑ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/ bleeding, polyps, hemorrhoids or any other digestive disorder or condition ❑ Yes ❑ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type:________) ❑ Yes ❑ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ❑ Yes ❑ No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio or any other musculoskeletal disorder ❑ Yes ❑ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation or prosthesis ❑ Yes ❑ No
13. Diabetes, thyroid, pituitary, adrenal or any other endocrine disorders ❑ Yes ❑ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ❑ Yes ❑ No
15. Is anyone on this form a candidate for or a recipient of an organ or bone marrow transplant? ❑ Yes ❑ No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery or any other skin conditions ❑ Yes ❑ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ❑ Yes ❑ No
18. Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction or penile implant ❑ Yes ❑ No
19. a) Breast disorder/cyst, lump, fibroid tumors, silicone injections or implants ❑ Yes ❑ No

    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ❑ Yes ❑ No

    c) Date and result of last pelvic exam/Pap smear for each female over 16:

    Name:________________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal

    Name:________________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal

    Name:________________ Mo/Day/Yr:______ ❑ Normal ❑ Abnormal

    ❑ N/A I have not had a pelvic exam/Pap smear.

    d) Is the individual, spouse or any dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? ❑ Yes ❑ No

    e) Are you intending to become pregnant in the next 18 months? ❑ Yes ❑ No
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ❑ Yes ❑ No
21. Diseases or problems of the ears or hearing, implant or hearing aid ❑ Yes ❑ No
22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. ❑ Yes ❑ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:________________________________ ❑ Yes ❑ No
24. Has any individual consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ❑ Yes ❑ No

Has any person listed on this form **ever**:

25. Had cancer, tumor/growth, leukemia or cyst? ❑ Yes ❑ No
26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery or treatment? ❑ Yes ❑ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? ❑ Yes ❑ No
28. Been diagnosed as having or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV (Human Immunodeficiency Virus)? ❑ Yes ❑ No

IMPORTANT: Medical conditions, which occur after the signature date and before the approval date that come to HTH Worldwide's attention, may be considered in any future underwriting decision.

Social Security No.
Visa/ Passport No.

5B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 5A. (Use additional sheets if necessary.)

Question #	Name of Family Member		Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness			Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)			Degree of Recovery	City	State	Zip Code	Fax No.
Results ❑Normal ❑Abnormal		❑Still under treatment		Medications			Frequency
If abnormal, please explain:				Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member		Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness			Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)			Degree of Recovery	City	State	Zip Code	Fax No.
Results ❑Normal ❑Abnormal		❑Still under treatment		Medications			Frequency
If abnormal, please explain:				Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member		Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness			Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)			Degree of Recovery	City	State	Zip Code	Fax No.
Results ❑Normal ❑Abnormal		❑Still under treatment		Medications			Frequency
If abnormal, please explain:				Dosage	Date Prescribed		Date Discontinued

5C. Prescription Medications –

List all medications not noted above taken within the last 12 months by any family member listed on this form.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/Zip Code

5D. Other Health Questions

Question		1.		2.	
1. Has anyone on this form ever smoked or used any tobacco products such as: cigarettes, cigars, pipe, snuff or chewing tobacco?	❑ Yes ❑ No	1. Family member	Amount per day	2. Family member	Amount per day
		Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has anyone on this form used illegal or controlled drugs or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent?	❑ Yes ❑ No	1. Family member		2. Family member	
		Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has anyone on this form ever used any illegal or controlled I.V. drugs?	❑ Yes ❑ No	1. Family member		2. Family member	
		Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has anyone on this form consumed any alcoholic beverages in the last 6 months? Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	❑ Yes ❑ No	1. Family member		2. Family member	
		Amount ________ per ❑ day ❑ week ❑ month		Amount ________ per ❑ day ❑ week ❑ month	
		Type of Product		Type of Product	
5. Has anyone on this form been advised to reduce alcohol intake within the past 10 years?	❑ Yes ❑ No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed. ☐ **No. of sheets attached**

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.

Agreement (All individuals listed on form)

I, the undersigned, agree to the following:

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.

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

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 summit court papers authorizing guardianship.

Yes. I Agree X ______________________________

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 by 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.

Signature	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