


GeoBlue Navigator Health Plan

Worldwide Health Insurance for International Students
and Faculty in the U.S. and Abroad



Offered through the
Global Citizens Association,
Washington, D.C.



Table of Contents

What is GeoBlue Navigator?	1
Plan Basics	2
Why choose GeoBlue Navigator?	3
How the Plan Works	3
How to Apply	4

Who is GeoBlue?

GeoBlue is an innovator and leader in helping world travelers and expatriates stay safe and gain easy access to quality healthcare all around the world.

What is GeoBlue Navigator?

Complete, affordable worldwide coverage designed for students (including Optional Practical Training (OPT) status), teachers and faculty.

Why Choose GeoBlue Navigator?

The GeoBlue Navigator® health plan meets the needs of international students and faculty by offering comprehensive worldwide benefits—inside and outside the U.S.—without the typical limits, eligibility conditions and benefit exclusions common among traditional plans.

GeoBlue Navigator is the premier health plan for students and faculty because it combines these benefits with concierge-level medical assistance and easy access to the Blue Cross and Blue Shield provider network, the largest provider network in the U.S. An elite community of carefully selected providers outside the U.S. GeoBlue Navigator gives students and faculty peace of mind, knowing they have the freedom to access top medical care no matter where their studies or assignments take them.

Does GeoBlue offer coverage for assignments shorter than 3 months?

For study or assignments inbound to the U.S., the minimum length of stay is 3 months under the GeoBlue Navigator plan. GeoBlue Voyager provides coverage for students and faculty traveling outside of the U.S. for short-term research, study or international experience.





Complete, affordable
worldwide coverage

Meet GeoBlue, an experience well beyond that of traditional health insurance.

GeoBlue provides unsurpassed service and the convenience of mobile technology to access the best medical care no matter what town, country or time zone.

Easy Access to an Elite International Provider Community

Accessing care in the United States

Certain GeoBlue plans allow members to access the Blue Cross and Blue Shield Blue Card PPO network within the United States. With BlueCard PPO, you can access in-network Blue Cross and Blue Shield doctors and hospitals across the U.S. so you can get the care you need when you need it. BCBS has built direct relationships with an expansive network of more than 1.7 million in-network providers, spanning every zip code in the United States. That's more board-certified doctors than any other health insurance company. While you can choose to see any provider you want, both in- and out-of-network, you'll typically pay less when you go to a provider in the Blue Card PPO network.

Easy Access to an Elite International Provider Community

GeoBlue has an elite network of doctors from most every specialty ready to see you in over 190 countries. Only a small fraction of doctors around the world meet GeoBlue's exacting standards—participation is by invitation only. We seek out professionals certified by the American or Royal Board of Medical Specialties who speak English, and we factor in recommendations by over 158 Physician Advisors from all over the world.

We assemble in-depth provider profiles so our members can choose with confidence, and we put formal contracts in place to ensure preferred patient access. GeoBlue doctors and hospitals bill us directly so you don't have to worry about filing a claim.

Emergency Evacuation and Centers of Excellence

GeoBlue coordinates emergency services with a worldwide network of contracted Regional Physician Advisors as well as air ambulance operators selected for their safety records. Members in need of life-saving medical intervention are treated in Centers of Excellence in the U.S. and around the world whenever possible.

Around-the-Clock Assistance Call Center

GeoBlue provides a 24/7, toll-free call center to assist GeoBlue members with everything from routine requests to medical emergencies. The GeoBlue staff has years of experience with international medical assistance and has close working relationships with our International Provider Community.

Unsurpassed Member Services

Direct Pay—Paperless, Cashless, Convenient

GeoBlue members can avoid paying out of pocket for care by using Direct Pay. Through this service participating providers outside the U.S. bill GeoBlue directly for covered medical treatment.

Personal Solutions

GeoBlue Navigator members enjoy a full range of personal solutions. Your online tool kit allows you to check medical symptoms, understand your health risks and access personalized prevention and wellness recommendations.

Informed Choice—To Get the Care You Need

If members experience unanticipated medical problems, they can request local, regional or global treatment alternatives through the Informed Choice service.

GeoBlue Travels with You

While traveling across the globe with the GeoBlue mobile app, members can quickly and conveniently find and access quality care using your mobile device.

Global TeleMD™

In addition to the worldwide network of healthcare professionals available through the GeoBlue health plan, we've teamed up with Teladoc Health to bring members Global TeleMD, a telemedicine smartphone app that provides unlimited, 24/7/365 access to doctor consultations by telephone or video, at no additional cost. Doctors are available within and outside the U.S. Prescriptions may also be provided, as appropriate (subject to local regulations).

Why Choose the GeoBlue Navigator Plan?

A Recognized Leader

GeoBlue is a recognized leader in international health insurance and medical assistance services, serving hundreds of thousands of world travelers annually.

Highest Standards of Service

GeoBlue meets the highest expectations of quality. GeoBlue has set new standards for international assistance services and for applying stringent criteria when contracting with doctors and hospitals.

World-Class Healthcare

GeoBlue has the expertise and capability to meet any medical need efficiently and effectively. This can be support for a minor issue or help for a major issue, no matter where you are.

Group Quotes Available

Educational organizations can cover groups with 25 or more enrollees. Group plan designs can be customized.

How the Plan Works

GeoBlue Navigator offers comprehensive benefits and a range of deductible options that allow members to select the right amount of insurance coverage for their budget and lifestyle. For a detailed benefit schedule, please see insert. To calculate your total out-of-pocket expense, add the deductible and coinsurance maximum together as a total.

For families, the deductible and coinsurance maximum is a multiple of 2.5.

After 364 days of continuous coverage, Navigator members may re-enroll in a plan that matches their existing benefits.

Optional Dental/Vision Upgrade:

GeoBlue Dental and Vision benefits are designed to offer you coverage for common dental and vision care needs and to help you budget for dental services at all levels, preventive, basic and major.

For more information and eligibility, view the Plan Description on www.geobluetravelinsurance.com.

Plan Highlights

1. Flexible options for plan length.
2. Plan options that meet F1 and J1 Visa requirements.
3. Unlimited annual and lifetime medical maximum.
4. Contraceptive services and supplies are covered.
5. Comprehensive mental health services included.
6. Choice to see any healthcare provider outside of the U.S. and access to the Blue Cross Blue Shield PPO network in the U.S.
7. Pre-existing conditions covered with proof of prior health insurance.
8. Illnesses and injuries related to terrorism are covered.
9. Includes prescription coverage. Optional dental, vision, and maternity coverage.
10. Unlimited telemedicine services.
11. Medically necessary COVID-19 testing and treatment is covered.

Choose the Proper Level of Coverage

GeoBlue Navigator offers comprehensive benefits and a range of deductible options that allow members to select the right amount of insurance coverage for their budget and lifestyle.

GeoBlue Navigator Options				
Plan	Deductible*			Coinsurance Maximum
	Outside U.S.	U.S. In-Network	U.S.Out-of-Network	
0**	\$0	\$0	\$0	\$1,000
250**	\$125	\$250	\$500	\$2,000
500**	\$500	\$500	\$500	\$3,000
1,000	\$500	\$1,000	\$2,000	\$4,000
2,500	\$1,250	\$2,500	\$5,000	\$8,000
5,000	\$2,500	\$5,000	\$10,000	\$10,000

*Amounts paid to satisfy a deductible are credited to all other deductibles. Deductible waived for office visits.

**These plan choices meet and exceed the J1 Visa requirements.

How to Apply

Applications are available online or may be initiated by telephone or email. A personal check, money order or credit card number must accompany the application and must be sufficient to pay for one month of standard premium. GeoBlue will hold the form of payment until an underwriting decision is made. If your application is accepted, the payment will be applied to your account. Quotes obtained online or by telephone are advisory only. Actual premium is determined by the medical underwriting process.

GeoBlue will review your medical history as provided on the application and may request an Attending Physician's Statement. GeoBlue publishes standard premium rates for non-smokers. Smokers and other applicants with certain medical histories may be offered a plan at a higher rate. Not all applicants will be accepted. Your effective date of insurance will be on the 1st or 15th day of the month following underwriting approval.

Member Welcome Kit

When your application is accepted, GeoBlue will mail you and any family members covered under the plan a Welcome Kit with identification cards, a certificate of insurance and instructions on how to register online.

Procedures for filing a claim or requesting direct payment of participating providers will also be included.

About the Global Citizens Association

The Global Citizens Association is a national organization dedicated to promoting the interests of international travelers. Established more than 25 years ago, the GCA, is a not-for-profit affinity association located in Washington D.C., established to enhance global learning and lifestyles through safe and healthy world travel; to provide its members with useful international travel services and to make group international travel and health insurance coverages available to its members. Visit the GCA website (<https://www.gcassociation.org/>) to learn about the association's programs. This insurance

is available only to GCA members and by enrolling, you will become a member. Association enrollment fees are included in the amounts charged for the insurance. You are not obligated to purchase any services or products from the GCA. The GCA is not affiliated with any insurance company.

Eligibility

GeoBlue Navigator is designed for extended living abroad. You can choose to enroll in a new plan when your existing plan expires. When you do, there are no medical questions and premium rates do not change based on your individual claims history. Your new rate will be the same as all persons covered in your rating class.

How Coverage Ends

Your coverage ends on the earlier of:

1. The last day of the month after the date the Insured Person is no longer eligible;
2. The end of the last period for which premium has been paid;
3. The date the Policy terminates;
4. The date of fraud or misrepresentation of a material fact by the Insured Person, except as indicated in the Time Limit on Certain Defenses provision.

Extension of Benefits

If an Insured Person is Totally Disabled on the date of termination of the Policy, coverage will be extended until the earlier of:

1. The date payment of the maximum benefit occurs;
2. The date the Insured person ceases to be Totally Disabled; or
3. The end of 90 days following the date of termination.

Frequently Asked Questions

For more information and answers to frequently asked questions, visit www.geobluetravelinsurance.com.

Pre-existing conditions

The GeoBlue Navigator plan does not cover services for treatment of a medical condition for which medical advice, diagnosis, care, or treatment was recommended or received during 180 days immediately preceding the member's eligibility date.

Prior Health Insurance coverage

The 365-day pre-existing conditions period can be reduced or eliminated if you have been covered by a creditable group or individual health insurance plan.

For benefits, exclusions, eligibility and other important information, please see inserts.

● GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association.

GeoBlue Navigator Benefit Schedule

GeoBlue Navigator has three tiers of coinsurance: 100% outside the U.S., 80% in-network in the U.S., 60% out-of-network inside the U.S. All GeoBlue Navigator plans have an unlimited lifetime maximum and a \$250,000 maximum benefit for emergency medical evacuation.

The Out-of-Pocket Maximum is calculated by adding the deductible and coinsurance maximum together. Please refer to the chart on page 3 of brochure.

Benefits	Outside the U.S.	In-Network, U.S.	Out-of-Network, U.S.
Primary and Preventive Care – Insurer waives Deductible			
Primary Care Office Visits - as many as 8 visits per Calendar Year	All except a \$10 copay per visit ¹	All except a \$30 copay per visit	60% to Coinsurance Maximum then 100%
Preventive Care for Babies/Children: (Birth through Age 18) for Office Visits/Examination and Immunizations, Lab work & X-rays done in conjunction with an office visit	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Preventative Care For Adults: (Age 19 and Older) for Office Visits/examination, Immunizations as recommended by the Center for Disease Control (CDC), Routine Pap Smears, Annual Mammogram, PSA For Men, and Diagnostic lab work & X-rays done in conjunction with an office visit	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Travel Vaccinations, Subject to a Calendar Year Maximum of \$500	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Annual Physical Examination Health Screening, Subject to a Calendar Year Maximum of \$250 and limited to one per Calendar Year	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Urgent Care Facility	100%	All except a \$75 copay per visit	60% Coinsurance to Maximum then 100%
Outpatient Services – Insurer pays after the Deductible is Met			
Outpatient Medical Care	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Inpatient Hospital Services – Insurer pays after the Deductible is Met			
Surgery, X-rays, In-hospital doctor visits, Organ/Tissue Transplant	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Inpatient Medical Emergency ²	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Professional Services-Surgery, Anesthesia, Radiation Therapy, In-Hospital Doctor Visits, Diagnostic X-ray and Lab Work.	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Other Services – Insurer pays after the Deductible is Met, unless noted			
Ambulatory Surgical Center	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Physical/Occupational Therapy/Medicine, Limited to 6 visits per Calendar Year	100%, No Deductible	100%, No Deductible	100%, No Deductible
Ambulance Service	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Acupuncture and Chiropractic Services, Subject to a \$2,000 Maximum per Calendar Year if under the care of a licensed Physician	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Durable Medical Equipment	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Mental, Emotional or Functional Nervous Disorders, Alcoholism or Drug Abuse - Insurer pays after the Deductible is Met, unless noted			
Inpatient Mental Health	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Outpatient Mental Health	100%, No Deductible \$10 Copayment ¹	100%, No Deductible \$30 Copayment	60% to Coinsurance Maximum then 100%
Inpatient Substance Abuse	100%	80% to Coinsurance Maximum then 100%	60% to Coinsurance Maximum then 100%
Outpatient Substance Abuse	100%, No Deductible \$10 Copayment ¹	100%, No Deductible \$30 Copayment	60% to Coinsurance Maximum then 100%
Outpatient Prescription Drugs - Insurer waives Deductible			
Prescription Drug Benefit, Subject to \$5,000 Maximum per Insured Person per Calendar Year, Maximum 90-day supply	100% of actual charges	100% of actual charges	100% of actual charges
Global Travel Benefits – Insurer Waives Deductible			
Accidental Death and Dismemberment	Maximum Benefit: Principal Sum up to \$10,000		
Repatriation of Mortal Remains	Maximum Benefit up to \$25,000		
Emergency Medical Transportation	Maximum Lifetime Benefit for all Evacuations up to \$250,000		

¹Copay waived when visiting a GeoBlue contracted provider outside the U.S.

²Emergency room visits that do not result in inpatient admissions will be subject to a \$100 penalty.

This is intended to be a sample benefit schedule. Changes may occur to benefits, rates and terms annually.

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association.

GeoBlue Navigator® Health Plans

Application Instructions

Thank you for applying with GeoBlue®.

- GeoBlue Navigator is specially designed for members of the Global Citizens Association.
- Coverage is not guaranteed until approved in writing by GeoBlue. Do not cancel your current insurance coverage until you have been notified of approval by GeoBlue that your GeoBlue Navigator coverage is effective.

Instructions

Do not complete this application until you have read the current product brochure or website.

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

- **For your own protection, you, the applicant, must complete this application. You are solely responsible for its accuracy and completeness.**
- All information must be stated accurately.
- All questions must be answered in full or the application 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.
- This application must be received by GeoBlue within thirty (30) days from the signature date.
- Even if this application is approved, any intentional misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**
- Please return this application and your check to your agent OR mail to the address listed.

Payment Information

Please see page 7.

Most common causes for delay in underwriting

- 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 and results of last pelvic examination
- Incomplete or illegible information such as the mailing address does not include city, state and ZIP code.
- ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Additional documentation or information is required.

Mailing Address

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

GeoBlue
Attn: Individual Underwriting Department
933 First Ave.
King of Prussia, PA 19406

Expediting an Application

- To expedite underwriting please fax to 610.482.9953 or email underwriting@geo-blue.com.

www.internationalinsurance.com

GeoBlue Navigator Individual Enrollment Application

Application must be completed by the applicant in blue or black ink.

Applicant's Social Security No.

--	--	--	--	--	--	--	--	--	--

Visa/ Passport No.

--

Agent I.D. No. 112686

1. Applicant Information (Please Print)

Primary Applicant'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 <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 Applicant/Spouse (If applicable)	

2. Time and Location Status

What is your citizenship/nationality(ies)?
What is your host country or destination(s)?
How much time will you be away from your country of citizenship/nationality(ies) during the enrollment period?
<input type="checkbox"/> Under 3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 7-9 months <input type="checkbox"/> 10-12 months
How did you hear about GeoBlue?

3. Choice of Plan

GeoBlue Navigator (Includes Benefits in the U.S.)					
<input type="checkbox"/> 0	<input type="checkbox"/> 250	<input type="checkbox"/> 500	<input type="checkbox"/> 1,000	<input type="checkbox"/> 2,500	<input type="checkbox"/> 5,000
Dental and Vision Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No					

4. Applicants for Coverage

Relation	Last Name First Name M.I.	MUST BE ACCURATE		Date of Birth (MM/DD/YYYY)	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					

Applicant's Social Security No.

Visa/ Passport No.

Applies to couples or families:

All family members must apply for coverage to be eligible. If extenuating circumstances prevent all family members from applying, please attach detail and a determination will be made by the company whether or not the application can be considered.

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

If No, Why? _____

Are you a U.S. Citizen? ☐ Yes ☐ No

Are you a Permanent Resident? ☐ Yes ☐ No

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

4. Applicants for Coverage continued

Please list your occupation and duties.

Please provide the name of your institution, organization or company.

Please provide business address.

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

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

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

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

Are you a prior GeoBlue member? ☐ Yes ☐ No

B. Has anyone identified on this application 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

Eligible person(s)

C. Has anyone applying for coverage on this application 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

6. Health History – Include information on all family members you wish to enroll.**6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.**

Has any person listed on this application 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Sexually transmitted disease, such as herpes, genital warts, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy or any similar symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction or penile implant <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Chest pain, high cholesterol, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	19. a) Breast disorder/cyst, lump, fibroid tumors, silicone injections or implants <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever or any other circulatory condition <input type="checkbox"/> Yes <input type="checkbox"/> No	b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	c) Date and result of last pelvic exam/Pap smear for each female over 16: Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> N/A I have not had a pelvic exam/Pap smear.
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring or use of a sleep monitoring device <input type="checkbox"/> Yes <input type="checkbox"/> No	d) Is the applicant, spouse or any dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ (Temporomandibular Joint Dysfunction) <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids or any other digestive disorder or condition <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Diseases or problems of the ears or hearing, implant or hearing aid <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain or hepatitis (indicate type: _____) <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Eating disorder, depression, anxiety, attention deficit disorder, counseling, member of a support group, bi-polar, chemical imbalance, schizophrenia, obsessive-compulsive, panic disorder, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system <input type="checkbox"/> Yes <input type="checkbox"/> No	23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify: _____ <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation or prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application ever :
13. Diabetes, thyroid, pituitary, adrenal or any other endocrine disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Had cancer, tumor/growth, leukemia or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Is any applicant a candidate for or a recipient of an organ or bone marrow transplant? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT: Applicant's medical conditions, which occur after the signature date and before the approval date that come to GeoBlue's attention, may be considered in the final underwriting decision.

6B. Professional Services

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	If abnormal, please explain:		
	Name of Condition/Illness	Date Ended			
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	Medications	Frequency	
Results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Still under treatment	Dosage	Date Prescribed	Date Discontinued

Question #	Name of Family Member	Date of Onset	If abnormal, please explain:		
	Name of Condition/Illness	Date Ended			
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	Medications	Frequency	
Results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Still under treatment	Dosage	Date Prescribed	Date Discontinued

Question #	Name of Family Member	Date of Onset	If abnormal, please explain:		
	Name of Condition/Illness	Date Ended			
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	Medications	Frequency	
Results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Still under treatment	Dosage	Date Prescribed	Date Discontinued

6C. Prescription Medications –**List all medications not noted above taken within the last 12 months by any family member listed on this application.**

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued

6D. Other Health Questions

1. Has any applicant ever smoked or used any tobacco products such as: cigarettes, cigars, pipe, snuff or chewing tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> 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 any applicant 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant ever used any illegal or controlled I.V. drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	1. Family member		2. Family member	
	Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month		Amount _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> 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 by the applicant.



No. of sheets attached

Applicant's Social Security No.									
Visa/ Passport No.									

7. Conditions of Application

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

I, the undersigned, understand that, under the GeoBlue Navigator for which I am applying, I may be entitled to lesser benefits if I use a nonparticipating hospital, physician, or other provider, than if I use a participating hospital, physician or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 9, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 30-60 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance and will prevent you from being required to pay for two policies.

NOTE: If a child is born to the participant the child has to be registered within 31 days. All other children including adopted children must go through underwriting.

☐ I request that GeoBlue Navigator assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.

☐ 1st of ☐ 15th of

This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ONLY GEOBLUE CAN CHANGE THIS DATE, HOWEVER, GEOBLUE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN IS ISSUED.

Initial X

Initial Term

Please issue coverage for the initial term of:

- ☐ 3 months* ☐ 4 months* ☐ 5 months*
☐ 6 months ☐ 7 months ☐ 8 months
☐ 9 months ☐ 10 months ☐ 11 months
☐ 12 months

(Minimum of six months required for Missionary and Maritime Crew Plans.)

*Available to Students/Faculty only.

Billing Date

Charged on the 1st or 15th of the month (depending on your plan effective date).

Agreement (All applicants)

I, the undersigned, agree to the following:

- I understand and agree to pay the premium amount required with this application. If my application is denied, GeoBlue will return the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
- I agree to become a member of the Global Citizens Association and acknowledge that membership is subject to the terms and conditions set forth in the Membership Agreement which will be mailed to me with my welcome packet. Prices include a \$3.50 per person annual membership fee for the Global Citizens Association (GCA). If you are already a member, your membership will be extended for 12 months. Members may request a pro-rated adjustment of current membership fees. Please contact GCA at admin@gcassociation.org.

- If my application for GeoBlue Navigator coverage is accepted as

applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by GeoBlue that my application is approved.

- I understand that GeoBlue has the right to deny my application and if it does so, I will be notified in writing and the premium I submitted will be returned.
- 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 application regarding minor children.
- CONCERNING DEPENDENTS AGE 18 AND OVER: I represent that my dependents age 18 and over (1) have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 6A, 6B, 6C and 6D with them and (3) all information contained in this application regarding them is complete and accurate.
- I understand and agree that if GeoBlue rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, and/or cashing of my premium check or charging this amount to my credit card by GeoBlue does not constitute approval of my application or create GeoBlue Navigator coverage.
- If I am accepted, this application will become part of the agreement between the insurance carrier and myself.
- GeoBlue may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, GeoBlue will determine payment, and I will be responsible for any difference.
- The selling agent has no authority to promise me coverage or to modify underwriting or terms of any GeoBlue Navigator coverage.
- I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. GeoBlue may void all coverage from the original effective date of the 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 application.

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

Association Membership

I understand that this product is being offered only to members of the Global Citizens Association. I agree to become a member of the Association at no obligation. As a member of the Association, I shall be entitled to a variety of benefits, which includes the ability to purchase this insurance product. For further information visit www.gcassociation.org.

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 be subject to civil or criminal penalties, depending upon state law.

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.

Authorization/Disclosure Statement

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide GeoBlue’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 an application 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 Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 10). I have read and understand this Application in its entirety. I certify that I have received an outline of coverage.

Important details about this plan and the Affordable Care Act:

THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

If at any time during its term, this policy coverage is in conflict with any laws, statutes or regulations of the U.S. federal government or any of its agencies, the insurer shall have the right to exchange this policy with a substitute plan.

To see if you are required to purchase Minimum Essential Coverage and to learn more details, please visit our Affordable Care Act page: <https://www.geobluetravelinsurance.com/marketing/AHA.cfm>.

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

Notice of Information Practices

If you apply for or are covered by a GeoBlue health care plan, GeoBlue 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, GeoBlue may provide information to a hospital in order to verify benefits. Upon your request, GeoBlue 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. GeoBlue can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

Applicant's Social Security No.

Visa/ Passport No.

ATTACH INITIAL PREMIUM CHECK HERE.
DO NOT TAPE.

8. Payment Method – Submit initial premium with application (required).

8A. Initial Deposit

1 month premium \$ _____ <input type="checkbox"/> I am attaching a check/money order for the above amount <input type="checkbox"/> Please charge my credit card for the above amount	3 month premium \$ _____ <input type="checkbox"/> I am attaching a check/money order for the above amount <input type="checkbox"/> Please charge my credit card for the above amount
6 month premium \$ _____ <input type="checkbox"/> I am attaching a check/money order for the above amount <input type="checkbox"/> Please charge my credit card for the above amount	364 days premium \$ _____ <input type="checkbox"/> I am attaching a check/money order for the above amount <input type="checkbox"/> Please charge my credit card for the above amount
All checks should be made payable to Worldwide Insurance Services.	
Credit Card information (only if applicable) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover	
Cardholder's Name	Cardholder's ZIP Code
Authorized Signature (as it appears on the credit card) X	
Security Code* Expiration Date	
Today's Date	

* For Visa/Mastercard/Discover: The security code is the last three digits of the code in the signature panel on the back of the card.

For American Express: The security code is the 4 digits printed just above and to the right of the embossed credit card number on the front of the card.

8B. Payment Type (First payment will be credited to approved applicants only.)

Monthly Deduction

- ☐ From Checking Account
☐ Charge to Credit Card

Quarterly Deduction

- ☐ From Checking Account
☐ Charge to Credit Card

Semi-Annual Deduction

- ☐ From Checking Account
☐ Charge to Credit Card

Annual Deduction

- ☐ Charge to Credit Card

Checking Account and credit card deductions are done on the first or the 15th of the month depending on the effective date of the plan.

8C. Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated or if paying initial premium by credit card, attach a voided check. If the account listed below is a joint account, both account holders' signatures are required. **GeoBlue must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

AUTHORIZATION: As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of GeoBlue provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will be the same as if it were a check drawn on you and signed personally by me. I authorize GeoBlue to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my GeoBlue Navigator premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 364 days, you may re-apply for the monthly checking account deduction option.

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature (as it appears in the financial institution's records)	Date	Authorized Signature (as it appears in the financial institution's records)	Date	

(Continued on reverse)

DO NOT WRITE BELOW

The coverage requested may not be available.

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield Association. GeoBlue is the administrator of coverage provided under insurance policies issued by 4 Ever Life International Limited, Bermuda, an independent licensee of the Blue Cross Blue Shield Association.

Applicant's Social Security No.

Visa/ Passport No.

9. 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 Application (Section 7)."

By X _____ Signature of Translator Today's Date (Required)

10. Conditional Receipt – To be completed by the agent and given to the applicant.

Received from _____ \$ _____ as a premium, payable to Worldwide Insurance Services.

Subject to the following:

IN NO EVENT SHALL GEOBLUE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE PREMIUM SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY GEOBLUE.

Dated this _____ day of _____, 20 _____.

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By X _____ Signature of Agent 112686 Agent I.D. Number

Contact Us:

International Citizens Group, Inc.
18 Shipyard Drive
Suite 2A
Hingham, MA 02043

Visit www.internationalinsurance.com

Email info@internationalinsurance.com

Call 617-500-6738

Fax 877-758-4881

