reside® prime worldwide medical plan

Annual Medical Premiums Effective February 1, 2009

worldwide coverage including united states and canada (geographical treatment areas a & b)

	If you choose a $250 Annual Deductible		If you choose a $500 Annual Deductible		If you choose a $1,000 Annual Deductible		If you choose a $2,500 Annual Deductible		If you choose a $5,000 Annual Deductible	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
14 days through 18	$483	$483	$394	$394	$309	$309	$279	$279	$250	$250
19 through 29	$1,021	$1,597	$886	$1,422	$709	$1,029	$613	$885	$481	$753
30 through 39	$1,101	$1,763	$942	$1,588	$762	$1,150	$662	$1,010	$520	$838
40 through 44	$1,467	$1,989	$1,342	$1,747	$1,073	$1,345	$924	$1,223	$721	$1,057
45 through 49	$1,698	$2,039	$1,531	$1,885	$1,182	$1,474	$1,063	$1,307	$869	$1,082
50 through 54	$2,019	$2,219	$1,809	$2,033	$1,445	$1,619	$1,338	$1,459	$1,074	$1,176
55 through 59	$2,629	$2,554	$2,327	$2,319	$1,900	$1,773	$1,609	$1,564	$1,350	$1,308
60 through 64	$3,693	$3,496	$3,453	$3,215	$2,747	$2,552	$2,591	$2,406	$2,178	$1,915
65 through 69	$7,386	$6,641	$7,125	$6,242	$6,622	$5,675	$5,119	$4,724	$4,496	$4,144
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child	$438	$438	$374	$374	$280	$280	$254	$254	$225	$225

worldwide coverage excluding united states and canada (geographical treatment area b)

	If you choose a $250 Annual Deductible		If you choose a $500 Annual Deductible		If you choose a $1,000 Annual Deductible		If you choose a $2,500 Annual Deductible		If you choose a $5,000 Annual Deductible	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
14 days through 18	$370	$370	$302	$302	$237	$237	$214	$214	$191	$191
19 through 29	$771	$1,206	$670	$1,074	$535	$776	$463	$669	$363	$569
30 through 39	$815	$1,304	$697	$1,175	$563	$851	$490	$748	$385	$620
40 through 44	$1,093	$1,482	$999	$1,302	$799	$1,002	$689	$911	$537	$788
45 through 49	$1,256	$1,509	$1,133	$1,395	$874	$1,092	$787	$967	$643	$801
50 through 54	$1,524	$1,676	$1,365	$1,535	$1,091	$1,223	$1,010	$1,102	$810	$888
55 through 59	$1,972	$1,915	$1,745	$1,739	$1,425	$1,329	$1,207	$1,173	$1,013	$980
60 through 64	$2,751	$2,605	$2,573	$2,395	$2,046	$1,901	$1,930	$1,793	$1,624	$1,427
65 through 69	$5,465	$4,914	$5,273	$4,620	$4,901	$4,199	$3,788	$3,496	$3,327	$3,067
70 through 74	Contact Your Agent or Seven Corners for Rates									
Dep. Child	$333	$333	$285	$285	$214	$214	$193	$193	$171	$171

premiums for optional benefits

AD&D Principal Sum Rider:

Benefit	Annual Premium	
$100,000	$143	Primary Insured and/or Spouse
$200,000	$286	Primary Insured Only
$300,000	$429	Primary Insured Only
$400,000	$572	Primary Insured Only
$500,000	$715	Primary Insured Only
Child $10,000	$15	

Dental Rider:

For U.S. Citizens:
$359 annually per person

For non-U.S. Citizens:
$508 annually per person

(if selected for one, then all applicants must purchase the option)

Sports Rider:

$240 annually per person

(if selected for one, then all applicants must purchase the option)

Hospital Indemnity Benefit Rider:

Benefit is an additional $150 per night for a covered hospital admission, maximum thirty (30) nights per policy period.

$145 annually per person

(if selected for one, then all applicants must purchase the option)

*The Dependent Child Premium is only available when one parent *(legal guardian)*, of a natural or legally adopted unmarried child over fourteen (14) days old and under nineteen (19) years of age *(or under twenty-four (24) years of age if attending a university full-time and must rely on parents for support)*, is also covered under the same program. No medical premium is charged for the first two (2) Dependent Children between the ages of fourteen (14) days and nine (9) years old if both parents are also covered under the same program.

If the Applicant desires to pay premiums on a Semi-Annual, Quarterly or Monthly basis, they must do so by credit card payment only. Seven Corners will automatically debit the credit card on the due date of the premium installment. The Premium Installment Factors to be applied to the Annual Premium are as follows:

Annual 1.00 / Semi-Annual 0.55 / Quarterly 0.28 / Monthly 0.10

IMPORTANT NOTICE: The premiums referenced above are applicable for the initial twelve (12)-month coverage period, only after the Applicant has been accepted by Seven Corners. Seven Corners reserves the right to increase the stated premiums based upon the Applicant's medical condition at the time of application and underwriting. Applicants with chronic and/or severe medical conditions may be declined. At each renewal period, Seven Corners will inform the Applicant of the renewal premium for each subsequent coverage period based upon the Applicant's age and deductible category.

Attention Applicants: Certain Underwriters at Lloyd's of London, operates as an approved Surplus Lines market in the United States. The premiums listed above include a general Surplus Lines Tax. Your State of Residence may warrant an additional Surplus Lines Tax, Stamping Fees and administration fee. Upon receipt and review of your application, Seven Corners will inform you if additional Surplus Lines Taxes and fees will apply. If so, Seven Corners will request the payment of the additional Surplus Lines Taxes and fees from you prior to issuing coverage. The additional Surplus Lines Taxes and fees shall be listed on the declaration page of your policy.

reside® prime application for coverage

2009 Reside Prime Worldwide Medical Plan – All Sections Must be Completed in Full

As described in the brochure and documentation, Reside Prime Worldwide Medical Plan is a comprehensive medical insurance program designed exclusively for the international citizen. In order to provide you and your family with the coverage you desire, please follow the directions and answer all questions in complete detail.

Please note that Reside Prime limits coverage in the United States and/or Canada to 6 months during any given 12-month Policy Period. This plan is not intended to cover permanent residents of the United States.

Directions For Completing The Application

1. Please print or type all information. Illegible information will delay underwriting and processing of your coverage.
2. Each family member requesting coverage must be listed on the Application. All questions on the Application apply to all applicants requesting coverage. Answer each and every question, as it pertains to each applicant listed on the Application. All members of a family must choose the same Deductible.
3. Each section of the Application must be completed in full. Any question where a "Yes" is marked must be described in detail in Section 4. Information. Section 4 must include the applicant's name, physician's name, address and phone number, diagnosis, prognosis, and course of treatment. If necessary, use an additional sheet of paper to describe the condition(s) and attach it to the Application when submitted to Seven Corners.
4. The Premiums listed are annual premiums and can be paid by check, money order, VISA®, MasterCard®, Diners Club®, American Express®, or Discover®. Due to the inconsistent reliability of international mail, monthly, quarterly and semi-annual payments can be made by using a credit card or ACH payment. Monthly, quarterly and semi-annual payment modes are only accepted with Pre-authorization to debit your credit card or checking account on the due date of your premium installment.
5. After Seven Corners underwrites your Application and determines that coverage should be issued, we will send you an ID Card and a Certificate of Coverage by mail. The Certificate of Coverage contains the full program wording and definitions. This package will also include details on how to submit a claim as well as information regarding Seven Corners' Pre-Notification Program.

All Sections Must Be Completed in Full

section 1. program options

1. Coverage Option:
   ❑ Worldwide Coverage Including United States and Canada *(Geographical Treatment Areas A and B)* **or**
   ❑ Worldwide Coverage Excluding the United States and Canada *(Geographical Treatment Area B)*
   Be certain to choose the correct premium in your premium calculation. Please note that Worldwide Coverage Excluding the United States and Canada excludes any expenses incurred in the United States or Canada. After you have made a selection, please keep in mind that you may not alter your coverage location option.
2. Please Choose Your Policy Period Medical Deductible: ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000
3. Would you like to include the Dental Option: ❑ Yes ❑ No
4. Would you like to include the Sports Option: ❑ Yes ❑ No
5. Would you like to include the Hospital Daily Indemnity Option: ❑ Yes ❑ No
6. Would you like to increase the Accidental Death and Dismemberment Benefit: ❑ Yes ❑ No
   If yes, to what amount: Primary Insured ❑ $100,000 ❑ $200,000 ❑ $300,000 ❑ $400,000 ❑ $500,000
   Spouse ❑ $100,000
   Child (each child) ❑ $10,000
   What is the Primary Insured's Annual Income? _____
   Accidental Death and Dismemberment (AD&D) benefit is limited to 7 times the Primary Insured's Annual Income for persons under the age of 55. Persons over the age of 55 may be limited to a lesser amount.

Requested Effective Date: _____ / _____ / _____ *(month/day/year) (Requested Effective Date must be within 60 days of application date. If the Insured Person is choosing Worldwide Coverage including the United States and Canada, they must leave the U.S. and/or Canada within 30 days of effective date. If accepted, official Effective Date will be advised by Seven Corners.)*

For the AD&D benefit *(including any increased amount)*, please provide the beneficiary:

Primary Insured: _____ Spouse: _____

Child #1: _____ Child #2: _____

Child #3: _____ Child #4: _____

section 2. applicant information:

Applicant's Name *(Last, First, Middle, Maiden)*	**Sex**	**Relationship**	**Date of Birth** *(MM/DD/YYYY)*	**Citizenship**	**Height** *Feet / Inches*	**Weight** *lbs*
		Primary				
		Spouse				
		Child #1				
		Child #2				
		Child #3				
		Child #4				

Address of Residence:
(must be outside the United States)

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Mailing Address:

Street: _____ City: _____

State: _____ Postal Code: _____ Country: _____

Home Phone: (____) _____ Business Phone: (____) _____ Fax: (____) _____
(please include area and/or country code)

Email: _____

Occupation of Primary Insured: _____
(If retired, previous occupation(s))

Name of Employer: _____

Duties of Occupation: _____

Occupation of Spouse: _____

Family Physician Name: **(Required)** _____

1. Do you understand this is an international program and not U.S. health insurance? ❑ Yes ❑ No
2. Do you understand that you are unable to be in the U.S. and/or Canada longer than 6 months during any given policy year? ❑ Yes ❑ No
3. Are you or any listed dependents currently in the United States and/or Canada? If yes, enter departure date below. ❑ Yes ❑ No
   When do you plan to depart the United States and/or Canada: _____ / _____ / _____ *(month/day/year)*
   Please note: *Individuals choosing Worldwide Coverage Excluding The United States and Canada must depart the United States and/or Canada prior to the effective date.*
4. Are any listed dependents who are age 19, 20, 21, 22 and 23 full-time students? *(if yes, please list schools and locations)* ❑ Yes ❑ No
5. Do you understand that should you maintain this coverage longer than 36 consecutive months, the Extended Coverage Benefit Schedule will apply starting in the 37th month? ❑ Yes ❑ No

section 3. underwriting questions for all applicants

In order for your Application to be processed successfully, each question must be answered truthfully for all applicants. Any answers to "yes" questions must be explained in Section 4 Health History Details. In addition, answers to "yes" questions require an Attending Physicians Statement (APS) dated within the past 90 days containing detailed information and medical records.

Within the past ten (10) years, have you or any applicant sought treatment or been advised to seek treatment for, been medically advised, referred, counseled, treated, had surgery, diagnosed or currently taking prescription medicine for: ***(Please 'check' all that apply and state in detail in Section 4. Health History Details.)***

yes no

- ❑ ❑ 1. Digestive system diseases or disorders *(including, but not limited to: gastritis, ulcers, esophageal regurgitation, hemorrhoids, colon or rectum disorders)*?
- ❑ ❑ 2. Cardiovascular and/or circulatory diseases or disorders *(including, but not limited to: elevated blood pressure, hypertension, elevated cholesterol, heart attack, angina, chest pains, arteriosclerosis, coronary insufficiency, thrombosis, phlebitis, vascular afflictions, rheumatic fever, heart murmur)*? If "Yes" attach Attending Physicians Statement *(APS)* and current blood pressure reading, dated within the past 90 days describing the cardiovascular and/or circulatory condition.
- ❑ ❑ 3. Respiratory diseases or disorders *(including, but not limited to: chronic cough, bronchial asthma, bronchitis, tuberculosis, lung disorders, emphysema, respiratory insufficiency, pleurisy pneumonia)*?
- ❑ ❑ 4. Diseases or disorders of the eyes, nose, ears and throat *(including, but not limited to: nasal septum deviation, chronic sinusitis, cataracts, glaucoma, allergies or hay fever)*?
- ❑ ❑ 5. Sexually transmitted diseases or immune deficiency disorder *(AIDS / ARC)*, tested positive for HIV or any related illness?
- ❑ ❑ 6. Diseases or disorders of the Pancreas, Liver, Gall Bladder or endocrine disorders *(including, but not limited to: obesity, pituitary or lymph glands, thyroid or metabolic disorders)*?
- ❑ ❑ 7. Diabetes? *(If "Yes", complete the following)*
  - a) Diabetic Type: _____ I or _____ II
  - b) Date Diagnosed: _____ / _____ / _____ *(MM/DD/YYYY)*
  - c) Medications: Type: _____ Dosage: _____
  - d) Controlled by diet only?: _____ Yes or _____ No
  - e) Date of last HbA1c Test: _____ / _____ / _____ *(MM/DD/YYYY)* HbA1c Results (1-10): _____
- ❑ ❑ 8. Diseases or disorders of the mental and nervous system (including, but not limited to: mental retardation, psychosis, mental or behavioral disorders, Down Syndrome or other chromosome disorders, depression, anxiety, chronic fatigue, eating disorders)?
- ❑ ❑ 9. Neurological disorders including but not limited to: multiple sclerosis *(MS)*, muscular dystrophy, Lou Gehrig's disease *(ALS)*, Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient ischemic attacks?
- ❑ ❑ 10. Addictive diseases or disorders *(including, but not limited to: alcoholism, chemical or drug abuse or addiction, or has any applicant used illegal drugs or used prescription medication, other than as prescribed)*?
- ❑ ❑ 11. Kidney or urinary tract system diseases or disorders *(including, but not limited to: kidney or bladder stones and infections)*?
- ❑ ❑ 12. Cell or blood diseases or disorders *(including, but not limited to: cancer, tumors, cysts, polyps or other growths of the skin or internal organs, hepatitis, leukemia or Kaposi's sarcoma)*?
- ❑ ❑ 13. Muscular or skeletal diseases or disorders and inflammation *(including, but not limited to: scoliosis, arthritis, rheumatism, gout, tendonitis, joint or vertebrae disorders, osteoporosis)*?
- ❑ ❑ 14. Have you or any applicant consulted a therapist, physician, chiropractor, psychologist, or health care practitioner for medical advice, medical treatment and/or preventative care? Have you or any applicant been hospitalized or undergone medical studies *(including, but not limited to diagnostic tests, x-rays, electrocardiograms, radiology or blood work)*?
- ❑ ❑ 15. For male applicants, diseases or disorders of the reproductive system *(including, but not limited to: prostate or elevated PSA level)*?
- ❑ ❑ 16. For female applicants, diseases or disorders of the reproductive system *(including, but not limited to: vaginal bleeding, fibroids, nodules, fallopian tubes, ovaries or uterus)*?
- ❑ ❑ 17. For female applicants, are you currently pregnant or have had a complicated pregnancy or delivery? If currently pregnant, when is the expected due date? _____ / _____ / _____ *(MM/DD/YYYY)*
- ❑ ❑ 18. Diseases or disorders of the breasts *(including, but not limited to: cysts, nodules, calcifications or abnormal mammogram)*?

section 3. underwriting questions for all applicants (continued)

- ❑ ❑ 19. Have you or any applicant ever been rejected, ridered, cancelled, or had premium increased for any Health, Life or Disability Policy?
- ❑ ❑ 20. Are you or any applicant currently hospitalized, disabled or unable to perform normal activities?
- ❑ ❑ 21. Any Congenital defect, physical disorder or deformity, or developmental problems not listed above?
- ❑ ❑ 22. In the last 12 months, have you or any applicant used any form of tobacco?
  If "Yes" what form of tobacco? _____ Quantity: _____ How often: _____
- ❑ ❑ 23. Have you or any applicant recently experienced any signs, indications, symptoms, diagnosis or treatment that would cause you to believe that you currently have a new medical condition?

section 4. health history details for applicants

List details for all "YES" answers to the Section 3 Underwriting Questions (use additional paper, if necessary). Incomplete answers may delay processing or result in denial of application.

Name of Person and Question #	Condition / Diagnosis, Treatment Medical Prescribed and Results of Treatment	Duration / Dates of Treatment	Physician / Clinic Address and Telephone #

Information about prior / other coverage

yes no

- ❑ ❑ 1. Have you been covered by another medical plan at any time during the past year?
- ❑ ❑ 2. Will you be covered under any other medical plan *(individual or group)* while you are covered under this plan?

For all "YES" answers, please provide the following information. If more than one situation applies, attach a separate piece of paper to describe each situation.

Name of Insureds: _____
Policy Number: _____
Type of Plan: _____
❑ Spouse's employer group plan ❑ Other group plan ❑ Individual plan
Insurance Company: _____ Phone: (___) _____
Effective Date: _____ / _____ / _____ *(MM/DD/YYYY)* Termination Date: _____ / _____ / _____ *(MM/DD/YYYY)*
Reason for termination:
❑ Left employment ❑ Employer canceled plan ❑ Non-Renewal

section 5. declaration and enrollment request / authorization to release medical information:

I hereby apply for the Reside Prime program and for the insurance provided by Certain Underwriters at Lloyd's of London (the "Underwriter"). I hereby subscribe to the Global International Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd's of London.

I represent that I have read the completed application and that all my answers and statements on this Application and any attachments hereto is complete and true to the best of my knowledge and belief. I understand that my qualification for insurance is based upon my answers and statements herein and that this information may be verified by Seven Corners, Inc. (the "Administrator"). I understand that no one has the authority to exclude or direct me to exclude any information sought by this form. I understand that the Administrator will rely on all information on this Application in determining whether or not to issue coverage and that any incorrect or incomplete information may result in a claim denial or loss of coverage.

I understand that benefits may be limited or excluded for conditions for which any insured person has received any medical diagnosis or treatment, or taken any medication, or realized the manifestation of a condition before his or her effective date, according to the pre-existing conditions limitations provisions of the plan.

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically-related facility, the Medical Information Bureau, Inc. (MIB, Inc.), consumer reporting agency, insurance or reinsuring company, or employer having certain information about me or my dependents to give Seven Corners, Inc. or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes, but is not limited to, information about: physical condition(s), health history(ies), avocation(s), age(s), occupation(s), and personal characteristics. This authorization includes information about drugs, alcoholism, mental illness, or communicable diseases.

I UNDERSTAND the information obtained by use of this Authorization will be used by the Administrator to determine eligibility for benefits. I ALSO AUTHORIZE the Administrator to release any information obtained to reinsuring companies, Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required, or as I may further authorize.

I UNDERSTAND that as a resident of a foreign jurisdiction, I may be subject to foreign laws with respect to the type and form of coverage in which I am enrolling. I also understand and agree that responsibility for complying with those foreign laws rests solely on me.

I UNDERSTAND that no coverage is effective until I am notified in writing by the Administrator and advised of the official Effective Date. I also UNDERSTAND that if I am not accepted for coverage by the Administrator, the sole obligation of the Administrator and the Underwriter is to return the premium. I also UNDERSTAND that coverage in the United States and/or Canada is limited to 6 months during any one 12 month policy period. I also UNDERSTAND that Lloyd's of London operates as an unauthorized insurer in most U.S. states and that claims may not be made against a state guarantee insurance fund. I UNDERSTAND and AGREE that this program is issued outside the United States and that the coverage may not comply with the minimum requirements set forth by any insurance jurisdiction, within or outside the United States.

I UNDERSTAND that this program is not, nor does it intend to be, a general United States health insurance policy.

I ALSO UNDERSTAND any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Signature of Applicant or Guardian	Date
Signature of Applicant's Spouse (if applicable)	Date

section 6. premium and payment information

Premium is due with the submission of the application.

1. Standard Medical Plan:	**2. Increase Additional AD&D Rider** (see Section 1 details)**:**	**3. Dental Rider:**	**4. Sports Rider:**	**5. Hospital Daily Indemnity Rider:**	**6. TOTAL:**
Annual Premium for each family member from the Premium table.	Annual Premium for each family member depending upon Principal Sum selected.	Annual Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Annual Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Annual Premium for each family member *(if selected for one, then all applicants must purchase the option).*	Add the Premium amounts for each column chosen. Medical is required, the others are optional.
Applicant: $ _____	Applicant: $ _____	Applicant: $ _____	Applicant: $ _____	Applicant: $ _____	Applicant: $ _____
Spouse: $ _____	Spouse: $ _____	Spouse: $ _____	Spouse: $ _____	Spouse: $ _____	Spouse: $ _____
1st Child: $ _____	1st Child: $ _____	1st Child: $ _____	1st Child: $ _____	1st Child: $ _____	1st Child: $ _____
2nd Child: $ _____	2nd Child: $ _____	2nd Child: $ _____	2nd Child: $ _____	2nd Child: $ _____	2nd Child: $ _____
3rd Child: $ _____	3rd Child: $ _____	3rd Child: $ _____	3rd Child: $ _____	3rd Child: $ _____	3rd Child: $ _____
4th Child: $ _____	4th Child: $ _____	4th Child: $ _____	4th Child: $ _____	4th Child: $ _____	4th Child: $ _____
Subtotal A: $ _____	Subtotal B: $ _____	Subtotal C: $ _____	Subtotal D: $ _____	Subtotal E: $ _____	Total F: $ _____

	x		=	
Annual Premium for all applicants from TOTAL F		Installment Factor (see below)		**Total Initial Payment**

Installment Factor: ❑ Annual = 1.00 ❑ Semi-Annual = 0.55 ❑ Quarterly = 0.28 ❑ Monthly = 0.10

Important: Checks and Money Orders accepted for Annual Premium only from U.S. banks

method of payment

❑ Check ❑ Money Order ❑ Visa® ❑ MasterCard® ❑ Discover®/Novus® ❑ American Express® ❑ Diners Club International®

Card Number: | | | | | | | | | | | | | | | | Expiration Date: _____ / _____ (month/year)

CVV: _____

Name as it appears on the Card: _____

Daytime Phone: (___) _____ Alternate Phone Number: (___) _____

Signature *(Required)*: _____

Billing Address: _____ City/State/Zip: _____

All premium payments must be made in U.S. dollars. Checks must be issued from a U.S. bank and made payable to "Seven Corners." If paying by credit card, I authorize Seven Corners to debit my credit card account for the total amount due. In the event that I have elected to *Pre-Authorize credit card payment installments, I hereby request and authorize Seven Corners to debit my credit card periodically as payment installments become due. This authorization will remain in effect until revoked by me in writing, and until Seven Corners actually receives notice. Coverage purchased by credit card is subject to validation and acceptance by credit card company. *For any installment payment other than annual, I pre-authorize Seven Corners to debit my credit card for the proper installment amount on the due date of the installment. ***Check or money order should be made payable to Seven Corners. All payments must be made in U.S. dollars, from a U.S. bank, and submitted at the time application for coverage is made.***

agent information

Agent Name: _____ Seven Corners Agent #: 7315

Address: _____ City/State/Zip: _____

Phone: (___) _____ Fax: (___) _____ Email: _____

Agent Certification: I am not aware of any other information that may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this application nor any supplement to the application. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the application and the answers recorded to confirm completeness and accuracy.

Jesse Heim III _____ _____

Signature of Agent Date

Security: Certain Underwriters at Lloyd's of London; Rated A "Excellent" by A.M. Best and A+ "Strong" by Standard & Poor's.

Important Information

It is important to note that Reside Prime Worldwide is a program for international citizens and Lloyd's of London is an international entity. Thus, Lloyd's of London operates as an unauthorized insurer in most U.S. states. Coverage and benefits under Reside Prime Worldwide are not regulated by any U.S. state insurance department.
The information concerning Reside Prime Worldwide is not intended to be an offer to sell Reside Prime Worldwide or a solicitation by Seven Corners, Inc. or Lloyd's of London in any jurisdiction where such an action would be unlawful or in which Seven Corners or Lloyd's of London is not qualified to do so. Reside Prime Worldwide may not be available in all situations or jurisdictions. Reside Prime Worldwide is intended for persons living or traveling outside the United States.

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insurance carrier

Certain Underwriters at Lloyd's of London
Rated A "Excellent" by A.M. Best
A+ "Strong" by Standard & Poor's

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