

# SAFETRIP ENROLLMENT APPLICATION

**Notice:** Not available to Washington State residents.

Please call 1-800-732-5309 or 1-410-453-6380 between 8:00 A.M. - 5:00 P.M. ET Monday - Friday for telephone assistance. You may fax your enrollment to us at 1-410-308-7905. Mail application to: MEDEX Insurance Services, Inc., P.O. Box 19056, Baltimore, Maryland 21284

## Applicant Information

Name(s) Of Applicant(s):

Date Of Birth:

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_

Street Address

City

ST

Zip

Home Phone

Work Phone

Fax Number or Email Address

Group Name (If Applicable)

Are You A Permanent Resident Of The U.S.?  Yes  No

If No, List Country Of Permanent Residence

Emergency Contact Full Name

Emergency Contact Phone

## Primary Or Other Insurance Plan

Name

Policy Number

Phone Number

## Dates Of Coverage

From \_\_\_\_\_ Through \_\_\_\_\_ = \_\_\_\_\_ Total # of days of coverage

Countries Visiting

## Premium Calculation

1 Per Trip Enrollment  
7 day minimum, 90 day maximum per trip.

$\$3.50 * x \text{ ( \# of days )} = \$ \text{_____} \times \text{_____ ( \# of persons )} = \$ \text{_____}$

\*\$25.25 for ages 71-80

2a Annual Frequent Traveler  
No one trip can be more than 90 consecutive days.

$\$225.00 * x \text{ ( \# of persons )} = \$ \text{_____}$

\*\$280.00 for ages 71-80

2b Annual Expatriate  
For travel greater than 90 consecutive days or greater than 180 days in a 12 month period.

$\$350.00 * x \text{ ( \# of persons )} = \$ \text{_____}$

\*\$425.00 for ages 71-80

Total Premium Due: \$ \_\_\_\_\_

## Payment information

American Express  VISA  MasterCard  Check

Credit Card Number \_\_\_\_\_

Credit Card Security Number (optional) \_\_\_\_\_

Expiration Date (mm/yyyy) \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Cardholder Signature \_\_\_\_\_

Please make checks payable to MEDEX Insurance Services. Remittances accepted in U.S. funds only.

## Declaration Of Applicant

I hereby apply to purchase this program. I declare to the best of my knowledge and belief that the information given in this application is true and complete. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Member and the Company, and that any incorrect answers may void this coverage.

Signature

Date

FOR OFFICE USE Payment by: Check / M.O. / Credit Card

Check# \_\_\_\_\_ Amount \_\_\_\_\_