

SAFETrip ENROLLMENT APPLICATION

Mail application to:
MEDEX Insurance Services, Inc.
P.O. Box 19056
Baltimore, Maryland 21284

Please call 800-537-2029 between 8:00 A.M - 5:00 P.M. EST Monday - Friday for telephone assistance. You may fax your enrollment to us at 410-308-7905.

APPLICANT INFORMATION

NAME(S) OF APPLICANT(S): _____ DATE OF BIRTH _____

1) _____

2) _____

3) _____

ADDRESS:

_____ Street Address

_____ City _____ State _____ Zip

HOME PHONE: _____

WORK PHONE: _____

FAX NUMBER: _____

EMAIL: _____

GROUP NAME: _____
(if applicable)

ARE YOU A PERMANENT RESIDENT OF THE U.S.? YES / NO

IF NO, LIST COUNTRY OF PERMANENT RESIDENCE

EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE: _____

PRIMARY OR OTHER INSURANCE PLAN:

NAME: _____

POLICY NUMBER: _____

PHONE NUMBER: _____

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 _____

DATES OF COVERAGE

FROM: _____ THROUGH: _____ = _____
total # of days of coverage

COUNTRIES VISITING: _____

PREMIUM CALCULATION

I. PER TRIP ENROLLMENT

7 day minimum, 90 day maximum per trip.

$\$3.50 \times \frac{\text{# of days}}{\text{# of persons}} = \$$ _____

* \$5.25 for ages 71-80

II A. ANNUAL FREQUENT TRAVELER

No one trip can be more than 90 consecutive days.

$\$225.00 \times \frac{\text{# of persons}}{\text{# of persons}} = \$$ _____

* \$280.00 for ages 71-80

II B. ANNUAL EXPATRIATE

For travel greater than 90 consecutive days or greater than 180 days in a 12 month period.

$\$350.00 \times \frac{\text{# of persons}}{\text{# of persons}} = \$$ _____

* \$425.00 for ages 71-80

TOTAL PREMIUM DUE: \$ _____

PAYMENT INFORMATION

Method of Payment (circle one):

American Express / VISA / MasterCard / Check enclosed
(payable to MEDEX Insurance Services)

CARD NUMBER: _____

EXPIRATION DATE: _____

CARDHOLDER: _____

SIGNATURE: _____

FOR OFFICE USE

Payment by: Check / M.O. / Credit Card

Check# _____ Amount _____