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Application for TravMed Choice

Underwritten By: ACE American Insurance Company – Philadelphia, PA 19106
Notice: Not available to residents of Washington State

Mail application to:
MEDEX Insurance Services, Inc.
P.O. Box 19056
Baltimore, MD 21284
Phone: 800-732-5309
Fax: 410-308-7905
8:00 A.M. - 5:00 P.M. ET, Monday - Friday

Application is hereby made for TravMed Choice based on the following statements and representations:

Applicant 1 Full Name: _____ Date of Birth: _____ (month/day/year)
☐ Ms. ☐ Mr.
Current Medical Conditions: _____ Citizenship: _____
Applicant 2 Full Name: _____ Date of Birth: _____ (month/day/year)
☐ Ms. ☐ Mr.
Current Medical Conditions: _____ Citizenship: _____
Permanent Address: _____
City & State/Province: _____ Postal/Zip Code: _____ Country: _____
Home Phone: _____ Work Phone: _____ Fax: _____
E-Mail: _____
Passport #: _____ Country of Issue:_____

Country(ies) of Destination: _____
Start Date: _____ End Date: _____
Total Number of days of coverage requested: _____

Emergency Contact: _____ Phone Number: _____

Primary or Other Insurance: _____ Policy No.: _____ Phone: _____
AD&D Beneficiary Name:_____ Relationship to Applicant: _____ Phone: _____

How did you hear about FrontierMEDEX? _____

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Coverage Specifics:

I. Are you traveling (check):

☐ U.S. Resident ☐ Non-U.S. Resident

II. Policy Maximum (check):

☐ $50,000 ☐ $100,000 ☐ $250,000 ☐ $500,000*
*$500,000 option is only available to U.S. Residents traveling outside of the U.S.

III. Deductible (check):

☐ $250 ☐ $100

IV. Sports Coverage (check):

☐ Yes ☐ No

Premium Calculations

A. Applicant # 1

_____	_____	_____	**X** _____	**=**_____
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Days of Travel*	Daily Rate (see brochure)	Individual Premium

Applicant # 2

_____	_____	_____	**X** _____	**=**_____
Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Days of Travel*	Daily Rate (see brochure)	Individual Premium

Applicant #1 Individual Premium + Applicant #2 Individual Premium = _____
A. Subtotal

*Minimum period of coverage is 7 days, the maximum is 365 days (in Oregon 180); include Start Date and End Date in calculating Days of Travel

Optional Coverages

(if you want to reduce your deductible, add a Sports Coverage, or both)

	A Subtotal
B. For $250 Deductible and Sports Coverage, multiply Subtotal by 1.2	**B** _____
C. For $100 Deductible only, multiply Subtotal by 1.12	**C** _____
D. For $100 Deductible and Sports Coverage, multiply Subtotal by 1.35	**D** _____
E. Enter final premium based on coverage A, B, C, or D	**E**

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Payment Method

☐ Check* ☐ Money Order

☐ American Express ☐ Master Card ☐ Visa

Card #: _____ Expiration Date: _____
(month/ year)

Billing Address: _____

City & State/Province: _____ Postal/Zip Code: _____ Country: _____

Name as it
appears on card: _____ Signature: _____

*Please make check payable to "MEDEX Insurance Services, Inc." Total payment for the full term of coverage is to be paid in U.S. Dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

If paying by credit card, I hereby authorize ACE American Insurance Company or its authorized agents to deduct the total premium due from my credit card.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

I hereby apply to purchase the insurance and agree that his declaration and the information given herein shall form the basis of insurance between the applicant(s) and the Insurer.

IMPORTANT NOTICE*: 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.

I certify that I have read the complete plan description, and understand the terms and conditions of coverage that apply to me including any limitations or exclusions that may apply to my coverage. Further, I understand there is no coverage for loss due to pre-existing conditions, unless this insurance is purchased within the required time period to waive the Pre-existing Medical Condition Exclusion.

Applicant's Signature: _____ Date: _____
(month/day/year)

*Please see state-specific notices below:

In 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.

In Louisiana, WARNING: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OR 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.

In Oregon, ANY PERSON WITH THE INTENT TO KNOWINGLY 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 THAT IS RELATED TO THE ACCEPTANCE OF THE RISK BY THE INSURER, MAY BE GUILTY OF INSURANCE FRAUD AND MAY BE SUBJECT TO PROSECUTION.