

Application for TravMed Abroad

Underwritten By: ACE American Insurance Company - Philadelphia, PA 19106

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 Abroad based on the following statements and representations:

Applicant 1 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Current Medical Conditions: _____ Citizenship: _____

Applicant 2 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Current Medical Conditions: _____ Citizenship: _____

Applicant 3 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Current Medical Conditions: _____ Citizenship: _____

Permanent Address: _____
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: _____ Policy No.: _____ Phone: _____

How did you hear of MEDEX Global Solutions? _____

Premium Calculations

Plan I. Per Trip Enrollment

7 day minimum, 90 day maximum per trip.

$\$4.00^* \times \frac{\text{_____}}{\text{(\# of days)}} = \$ \text{_____} \times \frac{\text{_____}}{\text{(\# of persons)}} = \$ \text{_____}$

*\$5.75 for ages 71-80, \$8.00 for ages 81-85

Optional Benefits

Optional coverage(s) can only be purchased in conjunction with Plan I.

Trip Cancellation and Interruption

Minimum coverage \$300, Maximum coverage \$5,000; Price 6% (.06) of coverage requested; Must be purchased more than 10 days prior to departure and is non-refundable.

$.06 \times \frac{\text{_____}}{\text{(coverage requested)}} = \$ \frac{\text{_____}}{\text{(total cost of coverage)}} \times \frac{\text{_____}}{\text{(\# of persons)}} = \$ \text{_____}$

Lost Baggage

Maximum Coverage: \$1,000; Limit per article: \$250; Deductible: \$100; Price: \$2.50 per person, per day that baggage is checked on common carrier.

$\$2.50 \times \frac{\text{_____}}{\text{(\# of days)}} = \$ \text{_____} \times \frac{\text{_____}}{\text{(\# of persons)}} = \$ \text{_____}$

Plan II. Annual Frequent Traveler

No one trip can be more than 90 consecutive days. Please call for quote if number of trips per year exceeds 5.

$\$200^* \times \text{_____} = \$ \text{_____}$

*\$250.00 for ages 71-80

Total Premium Due \$ _____

Payment Method

Check* Money Order

American Express Master Card Visa

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

Billing Address: _____

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.