

## Application for TravMed Choice

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 Choice 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: \_\_\_\_\_  
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 about MEDEX Global Solutions? \_\_\_\_\_

### 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



**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.**