TravMed International Application Forms

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

Please call 1-800-732-5309 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.

DETACH HERE

APPLICANT INFORMATION

Applicant: ______________________________
(print name as it appears on your passport)

Address: ______________________________
(for all correspondence) *Not available to residents of the state of Washington*
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____

Telephone Number: ______________________________

Fax or E-mail: ______________________________

Home Country: ______________ Date of Birth: __________
(maximum age 70)

Country of Permanent Residence and Passport No: ______________
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Destination Country(ies): ______________________________

Name of Emergency Contact in Home Country: ______________

Relationship: ______________________________

Telephone Number: ______________________________

Have you ever been insured under this policy? ❑ Yes ❑ No

Requested Effective Date: ______________________________

The effective date of this insurance cannot be prior to the date this application premium are received and approved by the Administrator.

Information on Spouse and Child to be insured

Spouse's Name: ______________________________

Sex: ____________ Date of Birth: ______________

Child's Name: ______________________________

Sex: ____________ Date of Birth: ______________

Child's Name: ______________________________

Sex: ____________ Date of Birth: ______________

Child's Name: ______________________________

Sex: ____________ Date of Birth: ______________

DECLARATION OF APPLICANT

I hereby apply to purchase the insurance. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I acknowledge (on behalf of the person(s) to be insured) that benefits will not apply to treatment arising from pre-existing medical conditions. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Insured Person and the Company. Further, I hereby subscribe to the International Sojourners Insurance Trust and acknowledge enrolling in this group coverage for which I am eligible under the contract issued by the Company.

______________________ __________ ______________________
Signature Date Telephone Number

PREMIUM CALCULATION

$ __________ Monthly Premium (total monthly premium of all persons to be insured)

\+ $ __________ Optional Monthly AD&D Premium

= $ __________ Total Monthly Premium

x $ __________ Number of Months Requested (12 month maximum)

= $ __________ Total Policy Premium*

* The minimum policy premium is six (6) times the total monthly premium, even if less than six (6) months of insurance is requested.

Beneficiary: ______________________________

PAYMENT INFORMATION

Method of Payment *(circle one):*

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

CARD NUMBER: ______________________________

EXPIRATION DATE: ______________________________

CARDHOLDER: ______________________________

SIGNATURE: ______________________________

This application and all correspondence should be mailed to the address above.