1 ENROLLMENT FORM *(Please print carefully)*

INSURED #1: ❑ Male ❑ Female

❑ Dr. ❑ Mrs.
❑ Mr. ❑ Ms.

*Last

*First *Middle Initial

*Date of Birth

*Address

*Address

*City

*State *Zip

*Telephone ( )

Beneficiary

*Destination

*Airline

*Charter

*Tour Operator

*Cruise Line

*Date of Initial Trip Payment / /

*Departure Date / / *Return Date / /

AGENCY ARC#

Agent ID#

*** Required Information**

Any person who knowingly and with intent defrauds any insurance company is subject to criminal and civil penalties. I represent that the above information is true and the dates reflect my intent to start and end my trip. The coverage goes into effect after the premium is paid, at 12:01 a.m. on the day after the postmark, telephone purchase, fax transmission date, or online purchase confirmation date. The Insurer reserves the right to reject any Enrollment Form. I understand there is no coverage for loss due to pre-existing medical conditions, unless this insurance is purchased within the required time frame to waive this exclusion. I understand that if payment is returned unpayable for any reason, the coverage becomes null and void. I also understand that any changes to this Enrollment Form do not change the coverage of the policy. I have read, understand, and agree to the terms and conditions of the Insurance as detailed in the Description of Coverage.

Signature Date