

TravMed Global Application Form

Mail application to: MEDEX Insurance Services, Inc. | P.O. Box 19056 Baltimore, Maryland 21284
 Please call 800-732-5309 between 8:00 A.M - 5:00 P.M. EST Monday - Friday for telephone assistance. You may fax your enrollments to 410-308-7905.

—Applicant Information

FIRST NAME OF APPLICANT: _____ MIDDLE INITIAL: _____

LAST NAME OF APPLICANT: _____

ADDRESS: *Not available to residents of the state of Washington*

 Street Address

City State Zip

FAX OR EMAIL: _____

HOME PHONE: _____

WORK PHONE: _____

DESTINATION COUNTRY (IES): _____

DEPARTURE DATE: _____

RETURN DATE: _____

NAME OF BENEFICIARY: _____

COUNTRY OF PERMANENT RESIDENCE: _____

PASSPORT NUMBER: _____ DATE OF BIRTH _____
 Maximum Age 70

PERSON TO BE CONTACTED IN THE EVENT OF AN EMERGENCY:

NAME: _____

HOME PHONE: _____

WORK PHONE: _____

RELATIONSHIP: _____

— Payment Information

Method of Payment (circle one):

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

CARD NUMBER: _____

EXPIRATION DATE: _____

CARDHOLDER: _____

SIGNATURE: _____

— Required Coverage

**\$250,000 Medical Expense Benefits
 with \$25,000 AD&D Benefit**

Minimum 2 weeks, Maximum 26 weeks

\$100 Deductible = \$21/Week

\$500 Deductible = \$17/Week

\$1,000 Deductible = \$14/Week

\$ _____ x _____ = \$ _____
 cost per week # of weeks Premium

— Optional Coverage

Trip Cancellation and Curtailment Benefit

\$500 Minimum, \$10,000 Maximum

This coverage is available only if purchased at least 10 days before the Departure Date.

Cost per Person: .05 x the coverage requested

_____ x .05 = \$ _____
 Amount of coverage requested (see premium page) Premium

Name of Traveling Companion: _____

— Optional Coverage

\$100,000 Additional AD&D Benefit

Minimum 2 weeks, Maximum 26 weeks

Cost per Person: \$3.50 x _____ = \$ _____
 # weeks Premium

TOTAL PREMIUM DUE: \$ _____

— 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 to be insured) that benefits will not apply to treatment arising from any pre-existing medical condition. 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 my eligibility in this group coverage for which I am eligible under the contract issued by the Company.

Signature _____ Date _____

— Purchase Information

HOW DID YOU HEAR ABOUT MEDEX?

PURPOSE OF TRAVEL? (i.e. business, pleasure)
