

To Enroll for Membership and Insurance

1. Complete this entire enrollment form, panels 7 and 8.
2. If paying by check or money order, please make payable to iTravelInsured and enclose in envelope with signed enrollment form.
3. Mail or fax completed enrollment form to:

I will use the Online Fulfillment Kit Option (see page 9 for details- an email address is required)

Contact Information Please Print Mr. Mrs. Ms.

Name (First) _____ (Last) _____

Address _____

City, State, Country, Zip _____

Email address _____

Phone _____

Date of departure _____ Date of return _____

Total Years	0 - 49	50 - 59	60 - 69	70 +
Factor	.0400	.0549	.0698	.1015

Program Cost Calculation (please complete the following for each traveler, using the appropriate factor from above). Factors are subject to change.

1) First Name _____ Last Name _____

Date of birth _____ Citizenship _____

_____ - _____ = _____	\$ _____ X _____ = \$ _____
Current year Birth year Total years	Cost of trip Factor Cost

2) First Name _____ Last Name _____

Date of birth _____ Citizenship _____

_____ - _____ = _____	\$ _____ X _____ = \$ _____
Current year Birth year Total years	Cost of trip Factor Cost

3) First Name _____ Last Name _____

Date of birth _____ Citizenship _____

_____ - _____ = _____	\$ _____ X _____ = \$ _____
Current year Birth year Total years	Cost of trip Factor Cost

4) First Name _____ Last Name _____

Date of birth _____ Citizenship _____

_____ - _____ = _____	\$ _____ X _____ = \$ _____
Current year Birth year Total years	Cost of trip Factor Cost

5) First Name _____ Last Name _____

Date of birth _____ Citizenship _____

_____ - _____ = _____	\$ _____ X _____ = \$ _____
Current year Birth year Total years	Cost of trip Factor Cost

Please attach a separate page, if necessary, to list all travelers and continue to panel 8.

Total Program Cost Calculation

Please add together the program cost of each traveler to determine your total program cost*.

\$ _____ + \$ _____ + \$ _____ + \$ _____ + \$ _____
 #1 Cost #2 Cost #3 Cost #4 Cost #5 Cost

+ \$ _____ = **Total Program Cost \$** _____
 Cost from attached pages

*The trip cost is subject to a \$500 minimum per traveler.

MEMBERSHIP I (we) hereby enroll for membership to the National Small Business Travel and Health Association.

CERTIFICATION I (we) hereby certify and represent that I (we) have read, or have had read to me (us), all statements and answers recorded on this enrollment form. They are true, complete and correctly recorded. I (we) confirm that all travelers listed on this enrollment form are medically able to travel on the date this coverage is purchased. I (we) understand and agree that subject to the acceptance of this enrollment form and payment of the program cost in full, coverage will begin at 12:01 a.m. on the day after this completed enrollment form is received. I (we) understand that if payment is returned unpayable for any reason, coverage becomes null and void.

X Signature of Applicant or Proxy

_____ Date _____ Phone _____

Payment Method Check (To iTravelInsured)

Money Order (To iTravelInsured) Mastercard Visa

American Express JCB Discover

If paying by credit card, I authorize iTravelInsured to debit my credit card account for the total charge as specified in Total Program Cost. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I agree to comply with the cardholder agreement.

Card# _____ Expiration date _____

Name on Card _____

Signature _____

Your Daytime Phone _____

Your Billing Address _____

Producer/Referrer # _____
Name _____
Address _____
City _____ Phone _____
State _____ Zip Code _____