

(please print or type using black ink)

Official Use Only:

Cert#:

Processed:

Eff. Date:

Agent:

applicant information

Mr. Mrs. Miss Ms

Last Name: _____

First Name: _____ M.I. _____

Country of Permanent, fixed Residence (Home Country) _____

Passport Number: _____

Passport Country: _____

for accidental death & dismemberment benefit:

Beneficiary: _____ Relationship: _____

us address of correspondence (address must be in the united states)

Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Work Phone: () _____ Home Phone: () _____

Email Address: _____

When did or will you arrive in the United States: ___/___/___ (MM/DD/YY)

Date you would like coverage to begin: ___/___/___ (MM/DD/YY)

Note: This program is not available to United States citizens. Your coverage must begin within twelve (12) months of your arrival in the United States. The minimum period of coverage is 5 days, maximum is 12 months. If 3 or more months of premium is sent, an automatic renewal notice will be sent to the address above. Total program length available is 12 months. Coverage cannot begin until you depart from your home Country and Seven Corners both receives and accepts your application and correct premium.

coverage specifics

Have you purchased insurance through Seven Corners before? No Yes

If Yes, ID Number: _____

Age 2 weeks to Age 69:

Plan A: \$50,000

Plan B: \$75,000

Plan C: \$100,000

Plan D: \$130,000

Age 70 to 99:

Plan J: \$50,000

Plan K: \$70,000

Selected Per Injury/Sickness

Deductible:

\$0

\$50

\$100

Ages 70 and over options:

\$100

\$200

Optional Pre-Ex Benefit

Yes

No

Paper Fulfillment

Yes

No

If there are one or more applicants below age 70 and one or more applicants age 70 and above, separate applications must be submitted.

calculating your plan cost (please complete entire section)

	Date of Birth (MM/DD/YY)	Monthly Rate	Daily Rate
Applicant: _____	(___/___/___)		
Spouse: _____	(___/___/___)		
Child: _____	(___/___/___)		
Child: _____	(___/___/___)		
Child: _____	(___/___/___)		
Total:		\$	\$

Minimum period of coverage is 5 days

Multiply Monthly Rate Total by number of months: _____ X _____

Monthly Total [A]: \$ _____

Multiply Daily Rate Total by number of days: _____ X _____

Daily Total [B]: \$ _____

Optional Pre-Ex Benefit (If Chosen) (Total of [A] and [B]) X 1.26: \$ _____

Total Payment Enclosed (Total of [A] and [B]): \$ _____

method of payment

Check Money Order MasterCard

Visa Discover American Express

Card Number: _____ CVV: _____

Expiration Date: _____ Daytime Phone: () _____

Name as it appears on Card: _____

Signature (Required) _____

Billing Address: _____

Make Check or Money Order Payable to: "Seven Corners". Total Payment for the Full Term of coverage requested on this application must be paid in U.S. Dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by credit card company. I declare that I agree to and have read and understand the terms and conditions of this product as outlined in this brochure and the program summary, including that coverage is not available to any U.S. citizen. I understand that pre-existing conditions, as defined in this brochure, are not covered. I understand that this is not a general health insurance product, but a limited benefit program designed to provide basic benefits under certain circumstances. I also understand that Lloyd's operates as an approved but non-admitted insurer in most US states and that claims may not be made against any state guarantee fund. I understand and agree that this program does not comply with any US state insurance law. I also understand any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an enrollment form, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I hereby subscribe to the Global International Trust and enroll in the group coverage for which I am eligible under the group contract issued by Certain Underwriters at Lloyd's, London. As signatory, I declare that I am affirming all statements for all persons listed on the application (and declare that I have the authority to do so).

Signature of Insured or Proxy (Required)

Date