

(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. \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)

Passport Number: \_\_\_\_\_

Issuing Country: \_\_\_\_\_

What do you consider your Home Country or Fixed Permanent Residence?

\_\_\_\_\_

**address of correspondence**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_

**for ad&d benefit:**

Beneficiary: \_\_\_\_\_

Relationship: \_\_\_\_\_

**for couple or family coverage**

Names of additional persons to be insured? Date of Birth

Spouse: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Child: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Child: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Child: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Child: \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

(please attach separate sheet for additional children)

**have you purchased insurance through seven corners before?**

Yes  No

**requested effective date of coverage:**

Month: \_\_\_\_ Day: \_\_\_\_ Year: \_\_\_\_

\*Note: Coverage cannot begin until Seven Corners receives your application and correct premium.

**calculating your premium**

Select Period of Coverage:

3-Months  6-Months  12-Months

**select plan type:**

Single (applicant only)  Couple  Family

(Be sure to use correct premium)

**premium**

Standard Program \$ \_\_\_\_\_

**standard upgrade options These options are only available under the 3 months Standard Program (if applicable)**

**option a**

Add Medical Coverage (no coverage in U.S.)  
(max. 60 days any one trip) \$ \_\_\_\_\_

**option b**

Increase Primary AD&D to: \$ \_\_\_\_\_ \$ \_\_\_\_\_

Plus Admin Fee: \$ 10.00  
(non-refundable)

Total Payment Enclosed: \$ \_\_\_\_\_

**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: \_\_\_\_\_

Only one Liaison Traveler program may be purchased for any given policy period. Make Check or Money Order payable to: "Seven Corners". Total Payment for the Full Term of coverage requested 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 hereby subscribe to the Sun Trust Bank as Trustee of the Chartis Group Insurance Trust (District of Columbia), Trust and enroll in the group coverage for which I am eligible under the group contract issued by The Insurance Company of the State of Pennsylvania, a member of Chartis Insurance.

Signature of Insured or Proxy (Required)

Date