Visit USA-HealthCare™ Insurance Enrollment Form

VISITOR INFORMATION (please print)

Insured Surname

First | Initial

Home Country Address

City

Postal Code | Country

Passport Number | Country of Citizenship

Beneficiary (You will be the beneficiary for your insured spouse & children.)

Arrival Date in the U.S. ______ / ______ / ______
month day year

U.S. MAILING ADDRESS

Send Insurance Certificate to this U.S. Address, in care of U.S. Resident:

c/o Name

Address

City

State | Zip Code

( ) ______ - ______
Home Phone

( ) ______ - ______
Business Phone

REQUESTED EFFECTIVE DATE

We request the coverage to begin on: ______ / ______ / ______
month day year

CALCULATING YOUR PREMIUM

Basic Plan

Choose Plan: ☐ Plan A ($50,000) ☐ Plan B ($100,000)

Choose Deductible: ☐ $250 ☐ $500 ☐ $1,000

	Date of Birth	Monthly Premium		# Months		15 Day Premium (if applicable)		
Insured	___ / ___ / ___ (month day year)	$ ____	x	____	+	$ ____	=	$ ____
Spouse	___ / ___ / ___	$ ____	x	____	+	$ ____	=	$ ____
Child (age 14 days thru 18 years)	___ / ___ / ___	$ ____	x	____	+	$ ____	=	$ ____
Child (age 14 days thru 18 years)	___ / ___ / ___	$ ____	x	____	+	$ ____	=	$ ____

Subtotal $ ____

Optional Benefits

☐ Add Additional AD&D Coverage

☐ Add Hazardous Activity Coverage

One Option, Multiply by **1.20**

Both Options, Multiply by **1.30** x ____

Total Premium $ ____

Enrollment Fee + 5.00

Total Payment Due $ ____

OFFICIAL USE ONLY

0103/25M

Cert # ______ PC # ______

Eff. Date ___ / ___ / ___ Date Rec'd ___ / ___ / ___

ENROLLMENT AGREEMENT

I hereby subscribe to the AIG Life 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 company of the American International Group of Companies (AIG). The insured(s) understand(s) that this insurance will not pay benefits for any medical expenses caused by any pre-exisiting condition (refer to Exclusions). All claims will be fully investigated. Refund of premium, less a $20 processing fee, will be returned only if a written request is received by Travel Insurance Services prior to the effective date of coverage. After the effective date of coverage, the premium is considered fully earned and non-refundable.

X ______ ______
Signature of Insured or Proxy | Date

PAYMENT

☐ Check or Money Order, payable to **Travel Insurance Services**. Must be U.S. dollars drawn on a U.S. bank.

☐ VISA ☐ MasterCard ☐ Discover

Card Number | Exp. Date ___ / ___

Card Holder Name

Billing Address

City, State, Zip

Signature

Mail completed Enrollment with payment to:

Insubuy, Inc.
4700 Dexter Dr, Suite 100,
Plano, TX 75093, USA

Or fax with credit card information only to:

Fax: 972-767-4470

Please note:

Incomplete forms will not be processed and will be returned.