

WorldMed™ Insurance Enrollment Form

TRAVELER'S INFORMATION (please print) CONFIRMATION MAILING ADDRESS

(Complete only if different from Traveler's Information.)

Last Name (Surname)

First Name Initial

Home Country Address

City State / Province

Zip / Postal Code Country

Passport Number Country of Citizenship

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

Trip Destination

Email Address

c/o Name

Address

City State / Province

Zip / Postal Code Country

Daytime Phone

REQUESTED EFFECTIVE

Departure Date: ____ / ____ / ____
month day year

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

CALCULATING YOUR PREMIUM

Basic Plan	Choose Plan: Travel Inside the U.S. Travel Outside the U.S.
	<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B
	Choose Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500

Name	Date of Birth month / day / year	Monthly Premium	# Months	Total Your Payment
Insured	/ /	\$	x =	\$
Spouse	/ /	\$	x =	\$
Child (age 14 days thru 18 years)	/ /	\$	x =	\$
Child (age 14 days thru 18 years)	/ /	\$	x =	\$
Subtotal				\$
Optional Benefit	<input type="checkbox"/> Add Recreational Hazardous Activity	Multiply by 1.20		x
Total Premium				\$
Enrollment Fee				+ 5.00
Total Payment Due				\$

OFFICIAL USE ONLY

Cert # _____	PC # _____	0305
Eff. Date ____ / ____ / ____	Date Rec'd ____ / ____ / ____	

ENROLLMENT AGREEMENT

I hereby subscribe to the AIG Group Insurance 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 for any medical expenses incurred due to any pre-existing 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 by the insurance company 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 U.S. bank.

VISA MasterCard Discover

Card Number _____ / _____
Exp. Date

Card Holder Name _____

Signature _____

Billing Address _____

City, State, Zip _____

Mail to: **Insubuy, Inc.**
4700 Dexter Dr, Suite 100
Plano, TX 75093 USA

Fax to: 972-767-4470 (credit card payments only)

Buy online: insubuy.com
Be sure to enter the PC # (see "Official Use Only" box above) where requested.

Please note: Incomplete forms cannot be processed and will be returned.