Insubuy®, Inc. 4200 Mapleshade Ln, Suite 200, Plano, TX 75093 | Phone: (866) INSUBUY | Fax: (972) 767-4470 | info[at]insubuy.com

Producer #: 25735

Application Form - Page 1 of 2

This is a temporary major medical insurance plan intended for **reimbursement** of eligible expenses from injuries or illnesses which occur within a specified geographical area. Benefits may be assignable once validated. Until then, benefits are paid directly to you to reimburse you for necessary medical expenses which have been paid by you, subject to covered expenses as outlined in the certificate.

Applicant Information (A)

This is not an Affordable Care Act (ACA) compliant plan. This plan is not availiable for US citizens. If you become a US citizen this coverage will automatically terminate.

1) Are you a US Citizen? ❍Yes ❍No

Name (Last, First)	Date of Birth	Gender	Travel Dates*
	/ /	M / F	/ / thru / /

*Not to exceed 11 months.

Number & Street _____

City _____ State_____ Zip Code _____

Email _____ Telephone (_____)_____-_____

Coverage Amount

Deductible: $_____ Maximum Benefit: $_____

Optional Coverage

❑ Cardiac / Cancer Benefit Increase Option

❑ War & Terrorism Coverage • Specify Countries _____

❑ Sports or Activities Coverage • Specify Sport or Activity _____

Payment Options

Please complete the payment authorization form on the following page.

Declaration

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that this is a temporary insurance policy designed to reimburse the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product.
I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured: _____ Signature: _____ Date: _____
Please Print

Guardian of Insured: _____ Signature: _____ Date: _____
(If Applicant is under age 18) Please Print

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Payment Authorization Form

Insured's Name		
Account Billing Address		
City	State	Zip
Email		Phone

❍ In Full Payment - Premium Amount: $_____

❍ Pre-Authorized Monthly Payment - Premium Amount $_____

Option 1) Credit Card

Card #

Expiration Date: /

Security Code:

3 Digit Code

4 Digit Code

Option 2) Electronic Check

Select Account Type:

❍ **Checking**

❍ **Saving**

(Must be a U.S. Bank Account)

Routing # *(9-digits)*

Account #

Attach Voided Check

I understand that this authorization will remain in effect until Petersen International Underwriters receives a written request from me to cancel my automatic withdrawal at least 3 days prior to the next scheduled withdrawal or until Petersen International Underwriters elects to cancel this agreement. I understand that if two or more deductions are not honored, Petersen International Underwriters has the right to discontinue my enrollment in the Electronic Funds Transfer Payment Plan. I hereby authorize Petersen International Underwriters to debit my account for the correct installment premium on the due dates of the installments. I understand that my coverage is not in effect until all requirements have been submitted and approved by Petersen International Underwriters. I acknowledge that the origination of EFT transactions to my account must comply with the provision of U.S. law.

Signature: _____ **Date:** _____