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

Please type or print in ink.

LIAISON® INTERNATIONAL APPLICATION

OFFICIAL USE ONLY -
Agent: 6109

APPLICANT INFORMATION

Last Name: _____

First Name: _____ M.I.: _____

Residence Country: _____

Destination Countries: _____

List all destinations for your trip. We cannot cover travel to Islamic Republic of Iran & Syrian Arab Republic.

Passport Country & Number: _____

Departure Date from your Residence Country: *(MM/DD/YY)*____/____/____

Coverage Start Date: *(MM/DD/YY)*____/____/____

Coverage End Date: *(MM/DD/YY)*____/____/____
The minimum coverage period is 5 days, the maximum is 45 days.

Previously insured by Seven Corners? ❑ Yes ❑ No ID #: _____

Important: *We cannot accept an address in these locations:*
States in the USA: Maryland, Washington, New York, South Dakota, Colorado.
Islamic Republic of Iran, Syrian Arab Republic, U.S. Virgin Islands, Gambia, Ghana, Nigeria, and Sierra Leone.

MAILING ADDRESS:

Address: _____

City: _____ State: _____

Postal Code: _____ Country: _____

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

Email Address: _____

❑ I would like to receive communications from Seven Corners and/or my agent about products in the future.

AD&D BENEFICIARY DETAILS

Beneficiary: _____

Relationship: _____

CALCULATING YOUR PLAN COST

POLICY MAXIMUM:
❑ $50,000 ❑ $100,000 ❑ $500,000
❑ $1,000,000

WHERE ARE YOU TRAVELING?
To the U.S. ❑ Outside the U.S. ❑

*Use applicable Daily Rates from page 2.

Name of Persons to be Insured:	Date of Birth MM/DD/YY	Gender	Daily Rate* (USD)
Primary: _____	___/___/___	❑M ❑F	_____
Spouse: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____
Child: _____	___/___/___	❑M ❑F	_____

1. Add the amounts in the Daily Rate column together. Enter the result on line 1. This your Daily Rate Total. 1._____

2. Choose your Deductible from the chart below by placing an x in the appropriate box. Write the corresponding Factor on line 2. 2._____

Deductible	Factor	Deductible	Factor
❑ $0	1.3	❑ $500	0.9
❑ $100	1.1	❑ $1,000	0.8
❑ $250	1.0	❑ $2500	0.7

3. Would you like the optional Hazardous Sports Coverage? If one traveler wants this benefit, all insured travelers must purchase. 3._____
❑ Yes ❑ No If yes, enter 0.15 on line 3. If no, enter 0 on line 3.

4. Add line 2 and 3 together. Enter the result on line 4. This is your Total Factor. 4._____

5. Multiple line 1 by line 4. Enter the result on line 5. This is your Rate Adjustment Factor. 5._____

6. Enter your Total Number of Travel Days on line 6 (include all travel days & the start & end dates for your trip). 6._____

7. Multiply line 5 by line 6. Enter the result on line 7. This is your Total Payment. 7._____

METHOD OF PAYMENT

❑ Check ❑ Money Order ❑ MasterCard ❑ Visa ❑ Discover ❑ American Express

Card Number: _____ Expiration Date: _____ Daytime Phone: ( ) _____

Name on Card: _____ Billing Address: _____

Signature *(Required)* _____

Total payment for the full term of coverage must be paid in U.S. dollars when you apply. I hereby apply to be a Plan Participant of the Fairmont Specialty Trust (the "Trust") and to participate in the insurance coverage extended by certain underwriters at Lloyd's ('the Insurers') to Plan Participants under the Trust (the "Coverage") and enroll in the group coverage for which I am eligible under the group contract issued by Advent, Syndicate 780 at Lloyd's of London or the group contract issued by Tramont Insurance Company Limited. I understand that the Coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand and confirm that it is the responsibility of Indian residents purchasing insurance coverage to obtain permission from the Central Government and Reserve Bank of India before I can acquire insurance. I understand that I may obtain full details of the Coverage by requesting a copy of the Master Policy from the Plan Administrator. I understand that the liability of the Insurers as underwriters of the Coverage is as provided in the Master Policy. I understand and agree that no coverage will be in effect until such time that all premiums due are paid and my subscription agreement is accepted by the Insurance Company.

I hereby confirm the accuracy of all information, and validity of all representations and warranties provided to the Trustee in connection with my participation in the Plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this Subscription Agreement, (together "Representations & Warranties"). I acknowledge that such information will be relied upon by the Insurers and that any inaccuracy therein may result in the invalidity of the Coverage, the loss of Coverage and all monies paid in relation thereto. I hereby undertake to inform the Trustee of any change to any of the Representations & Warranties. I hereby indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any Representation & Warranty or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & Warranties. I agree that the Trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by me and I hereby undertake to indemnify and hold harmless the Trustee against any loss or damage (including attorney's fees) occasioned by the Trustee acting in accordance with any such instruction. I confirm that I have satisfied myself that the Coverage is appropriate for me and that I meet the eligibility criteria.

Seven Corners, Inc. is a US company and under the regulation of the Office of Foreign Assets Control (OFAC), which requires us to search the identity of each individual or company applying for insurance coverage from the country you have selected. In the event that your name or company is published on the OFAC "Specially Designated Nationals" or "SDNs" list, we will not be able to offer coverage to you and we will rescind your policy. For more information on OFAC, please visit this web-site: http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx

Completing Your Application - If paying by check or money order, make payable to Seven Corners, Inc. & mail with your application to ***Insubuy, Inc. - 4700 Dexter Drive, Suite 100 - Plano, TX 75093 USA****. Checks must be issued from a US bank. If paying by credit card, you may mail or fax to us. Credit card purchase is subject to validation & acceptance by the credit card company. Fax:* ***972-767-4470***

_____ _____
Signature of Insured or Proxy *(Required)* *(Proxy is someone acting on behalf of insured)* Date