APPLICATION

STIC13420-18 V1

Last Name: _____ First Name: _____ MI: _____

Home Country Address: _____

Passport Number/Country: _____

Destination: _____

AD&D Beneficiary: _____ Relationship: _____

Correspondence Address Same as Home Country Address

Name: _____

Address: _____

City: _____ State: _____ Postal Code: _____ Country: _____

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

Email Address: _____

Previously insured with Trawick International? ☐ Yes ☐ No

COVERAGE SPECIFICS

[A] Accident Medical Expense Benefit Daily Premium Rates:

(rates based on $250 deductible with a $25,000 Accidental Death and Dismemberment Benefit)

Maximum Limit	$50,000	$100,000	$250,000	$500,000	$1,000,000
Age	Daily	Daily	Daily	Daily	Daily
Up to age 21	$0.54	$0.68	$0.71	$0.74	$0.82
22 to 29	$0.80	$0.91	$1.00	$1.11	$1.25
30 to 39	$0.94	$1.11	$1.28	$1.48	$1.70
40 to 49	$1.62	$1.82	$1.90	$2.04	$2.70
50 to 59	$2.81	$3.21	$3.32	$3.46	$3.63
60 to 64	$3.52	$4.23	$4.40	$4.62	$5.22
65 to 69	$4.11	$4.51	$4.59	$4.74	$5.39
70 to 79	$6.80	$8.70	N/A	N/A	N/A
80 to 89	$10.83	N/A	N/A	N/A	N/A

Persons up to age 64 are eligible for all plans

Persons age 65 to 79 are eligible for $50,000 or $100,000

Persons age 80 to 89 and over are eligible for the $50,000 plan only.

[B] Number of Days

Requested Effective Date: ____/____/____ Requested Termination Date: ____/____/____ Number of Days [B] _____

Please note: The minimum initial period of coverage is 5 days, the maximum is 12 months.

[C] Deductible Options and Factors (multiply)

(rates based on $250 deductible with a $25,000 Accidental Death and Dismemberment Benefit) To increase or decrease the Deductible use these factors:

Deductible	$0	$50	$100	$250	$500	$1000	$2500	$5000
Factor	1.30	1.20	1.10	1.00	.90	.80	.70	.60

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[D] Coverage Options Factors - see page 5 for details: (multiply)

☐ Athletic Sports x1.20 and Monthly ☐ Class 1 (+$0) ☐ Class 2 (+$26)

[E] Additional Accidental Death and Dismemberment Rates: (add)

Option 1: Increase to $50,000 maximum benefit	Additional $0.25 per person per day - Available for all ages
Option 2: Increase to $100,000 maximum benefit	Additional $0.50 per person per day - Available for ages 19 up to 79
Option 3: Increase to $250,000 maximum benefit	Additional $1.75 per person per day - Available for ages 19 up to 69
Option 4: Increase to $500,000 maximum benefit	Additional $4.00 per person per day - Available for ages 19 up to 69
Option 5: Increase to $1,000,000 maximum benefit	Additional $8.00 per person per day - Available for ages 19 up to 69

Persons under age 18 are eligible for Option 1 only; Persons age 18 to 69 are eligible for all Options;
Persons age 70-79 are eligible for Option 1 and 2; Persons age 80 and older or are eligible for Option 1 only

Name of Person(s) to be insured:

	Date of Birth	Daily Rate - per person
Traveler 1:_____	____/____/____	$ _____
Traveler 2:_____	____/____/____	$ _____
Traveler 3:_____	____/____/____	$ _____
Traveler 4:_____	____/____/____	$ _____
		[A]Total Daily Rate: $ _____

Calculating Your Plan Cost

[A] Total Daily Rate - all Travelers	$
[B] Total Number of Days Covered	x
Subtotal	$
[C] Multiply Deductible Factor	x
Subtotal	$
[D] Multiply Coverage Option Factor (if applicable)	x
Subtotal	$
[E] Add AD&D Upgrade Rate (if applicable) # days x Rate = $	+
Total Payment Enclosed [A-E]	**$**

Method of Payment

Make Check or Money Order payable to "Icon Services" and must be in U.S. dollars and from a US bank.
We also accept MasterCard, Visa, Discover and American Express

Card Number:_____ Expiration Date: (MM/YY) _____/_____ CVV:_____

Name on Card:_____ Daytime Phone: (_____) _____

Billing Address:_____ City:_____

State:_____ Postal Code:_____ Country:_____

If paying by credit card, I authorize Icon Services to debit my Discover, VISA, MasterCard or American Express account for the amount specified above.
Coverage purchased by credit card is subject to validation and acceptance by the credit card company. Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of Application or prior to the Effective Date of Coverage. I understand this insurance contains a Pre-Existing Condition exclusion, and other restrictions and exclusions. I understand that if I am eligible for renewal of this insurance that it may be transacted on line and only before my current coverage expiration date. I understand that the information contained herein is a summary of the certificate and that I will receive my certificate upon acceptance by Trawick. I understand that GBG Insurance Limited, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. Claims under this insurance may not be made against any state guaranty fund. I understand and agree that the agent/broker/representative, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. I hereby apply for membership in the EGlobal Tourist Trust, Hamilton, Bermuda and for the insurance provided to me by GBG Insurance Limited, I understand the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden or unexpected event while traveling outside my Home Country as declared on my application.

_____ ____/____/_____
Signature of Insured or Proxy (Required) (Proxy is someone acting on behalf of Insured) Date

Agent Name/Writing Number **Insubuy, Inc.** - **100**

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