Medical Insurance Services Group
251 North Illinois Street, Suite 600, Indianapolis, IN, 46204 USA

VisitorSecure™ - Traveling Outside of Home Country

$0 Deductible	$0 Deductible per Injury or Illness				
	Maximum Limit	PLAN A	PLAN B	PLAN C	PLAN D
		$50,000	$75,000	$100,000	$130,000
	Age	Daily	Daily	Daily	Daily
	14 Days to 17 Yrs	$1.41	$1.66	$1.90	$2.47
	18 to 29	$1.16	$1.36	$1.56	$2.03
	30 to 39	$1.30	$1.54	$1.76	$2.29
	40 to 49	$1.41	$1.66	$1.90	$2.47
	50 to 59	$1.92	$2.23	$2.54	$3.30
	60 to 69	$2.13	$2.48	$2.82	$3.67
	Dependent Child**	$1.33	$1.57	$1.81	$2.35

$50 Deductible	$50 Deductible per Injury or Illness				
	Maximum Limit	PLAN A	PLAN B	PLAN C	PLAN D
		$50,000	$75,000	$100,000	$130,000
	Age	Daily	Daily	Daily	Daily
	14 Days to 17 Yrs	$1.17	$1.37	$1.57	$2.04
	18 to 29	$0.97	$1.14	$1.29	$1.69
	30 to 39	$1.09	$1.28	$1.46	$1.89
	40 to 49	$1.17	$1.37	$1.57	$2.04
	50 to 59	$1.60	$1.86	$2.12	$2.76
	60 to 69	$1.78	$2.07	$2.36	$3.06
	Dependent Child**	$1.12	$1.30	$1.50	$1.94

$100 Deductible	$100 Deductible per Injury or Illness				
	Maximum Limit	PLAN A	PLAN B	PLAN C	PLAN D
		$50,000	$75,000	$100,000	$130,000
	Age	Daily	Daily	Daily	Daily
	14 Days to 17 Yrs	$1.08	$1.28	$1.46	$1.91
	18 to 29	$0.89	$1.05	$1.21	$1.57
	30 to 39	$1.01	$1.18	$1.36	$1.77
	40 to 49	$1.08	$1.28	$1.46	$1.91
	50 to 59	$1.48	$1.77	$2.07	$2.68
	60 to 69	$1.66	$1.97	$2.30	$2.99
	70 to 79	$2.87	$3.30		
	80+* ($10k Limit)	$5.87			
	Dependent Child**	$1.02	$1.21	$1.39	$1.82

$200 Deductible	$200 Deductible per Injury or Illness		
	Maximum Limit	PLAN A*	PLAN B
		$50,000*	$75,000
	Age	Daily	Daily
	70 to 79 Yrs	$2.58	$2.97
	80+* ($10k limit)	$5.28	

These VisitorSecure rates are effective 04/01/2016 and subject to change.

* $10,000 Maximum Limit for age 80 and over

** Dependent Child rate (14 days through 17 years) is applicable when at least one parent will also be covered by VisitorSecure

VisitorSecure™ Application for Insurance
Tokio Marine HCC Medical Insurance Services Group
Lloyd's Coverholder

Personal Details Please provide the following details for all individuals to be covered. Missing or illegible information will delay processing.

Name (First and Last)	Date of Birth (MM/DD/YY)	Citizenship	Home Country	Daily Premium
Primary				1A
Spouse				2A
Child 1				3A
Child 2				4A

Complete Mailing Address	Subtotals (add lines 1 through 4 above)	A	
	Trip Duration (# of days)	B	
E-mail Address / Phone Number	Multiply line A by line B	C	
Select a Plan Level ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D	OPTIONAL Express Delivery Charge (If desired, choose only one option) ☐ US Delivery Enter $20.00	D	
Select a Deductible ☐ $0 ☐ $50 ☐ $100 ☐ $200	☐ Non-US Delivery Enter $30.00	E	
Date of Departure from Home Country _____ / _____ / _____ / Date of Return to Home Country _____ / _____ / _____ / Requested Effective Date _____ / _____ / _____	Sub Total Amount Due (add lines C through E)	F	
Beneficiary & Relationship	Florida Surplus (Tax): Traveling to Florida to work? ☐ Yes ☐ No / Not traveling to Florida		
Destination(s)	If yes, multiply Line F total by 1.0515	G	
	Total Amount Due (add lines F and G)	H	

Payment Information ☐ Check/Money Order* (Single Up-Front Payment Only) ☐ MasterCard ☐ VISA ☐ Discover ☐ American Express

Credit Card Number	Exp Date	
Name on Card	Phone #	
Billing Address		
City	State	Zip

*Payment by Check or Money Order: Checks and Money Orders should be made payable, in US dollars, to HCC Medical Insurance Services. Please send Check or Money Order along with this Application via mail or courier to Insubuy, Inc.
4700 Dexter Dr, Suite 100, Plano, TX 75093

Payment by credit card: I authorize Tokio Marine HCC Medical Insurance Services Group to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. 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.

Cardholder Signature	Date

Authorization

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda and for the insurance provided to members by Lloyd's. I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-notification Penalty and other restrictions and exclusions. I understand that if I am eligible for Extensions and Renewals of this insurance that they may only be transacted online and will not be effective unless such transaction is confirmed in writing by Tokio Marine HCC Medical Insurance Services Group, and I understand that Extensions may be transacted after my Effective Date and Renewals may be transacted only within the thirty (30) days immediately preceding my current coverage expiration date. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to Tokio Marine HCC Medical Insurance Services Group. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, 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.

Applicant Signature	Date	Spouse Signature	Date

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Producer ID Number:	Producer Name: insubuy.com
Company Name & Address: Insubuy, Inc. 4700 Dexter Dr, Suite 100 Plano, TX 75093	Telephone: (866) INSUBUY
	Fax: (972) 767-4470
Signature:	E-Mail Address: