

TravMed America Application Form

Mail application to: MEDEX Insurance Services, Inc. | P.O. Box 19056 Baltimore, Maryland 21284

Please call 800-732-5309 between 8:00 A.M - 5:00 P.M. EST Monday - Friday for telephone assistance. You may fax your enrollment to us at 410-308-7905.

— Applicant Information

PASSPORT NUMBER: _____ DATE OF BIRTH _____
Maximum Age 70

FIRST NAME OF APPLICANT: _____ MIDDLE INITIAL: _____

LAST NAME OF APPLICANT: _____

EMAIL or FAX NUMBER: _____

C/O CONTACT IN THE U.S.: _____

ADDRESS IN THE U.S.: *Not available to residents of the state of Washington*

_____ Street Address

_____ City State Zip

TELEPHONE NUMBER: _____

RELATIONSHIP TO APPLICANT: _____

COUNTRY OF PERMANENT RESIDENCE: _____

IS APPLICANT CURRENTLY UNDER MEDICAL CARE? YES / NO

IF YES, DESCRIBE: _____

POLICY START DATE: _____

POLICY END DATE: _____

DATE OF ARRIVAL IN THE U.S.: _____

NAME OF BENEFICIARY: _____

— Premium Calculation

Minimum of 10 Days, Maximum of 90 Days

AGE 3 - 60 YEARS Cost Per Person: \$5.25/DAY

\$5.25 X _____ + \$15.00 = \$ _____
of days of travel Enrollment Fee Premium

AGE 61 - 70 YEARS Cost Per Person: \$10.50/DAY

\$10.50 X _____ + \$15.00 = \$ _____
of days of travel Enrollment Fee Premium

TOTAL PREMIUM DUE:

\$ _____

— Payment Information

Method of Payment (*circle one*):

American Express / VISA / MasterCard / Check enclosed

(payable to MEDEX Insurance Services)

CARD NUMBER: _____

EXPIRATION DATE: _____

CARDHOLDER: _____

SIGNATURE: _____

— Declaration of Applicant

I hereby apply to purchase the insurance. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I acknowledge (on behalf of the person to be insured) that benefits will not apply to treatment arising from any pre-existing medical condition. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Insured Person and the Company. Further, I hereby subscribe to the International Sojourners Insurance Trust and acknowledge enrolling in this group coverage for which I am eligible under the contract issued by the Company.

Signature

Date