The Beacon Series Application

1. Please print legibly. Complete SECTION	ONS 1 - 7 and sign t	ne application								
Last Name: YAGOD				First Name: AL				MI:		
Complete MailingAddress for correspondence: 40 steadman street Moncton Moncton, New Brunswick Postal Code: E1C 4P4 Canada				Country of Citizenship: Canada				Start Date of Coverage (M/D/Y): 02/20/2024		
Daytime Telephone: 3105718071				Countries to be visited: 1. Colombia 3			Date of Dep 10/09/2023	Date of Departure(M/D/Y): 10/09/2023		
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.				2 4			End Date of 02/17/2025	End Date of Coverage (M/D/Y): 02/17/2025		
				Primary Applicant's Passport, SSN. or Driver's License #: AS819714						
If you require your Fulfillment Kit to be				Please provide an E-mail address. Email is required for extending coverage: alyagod18@gmail.com						
mailed to you, please check here:				Linairio	3 required for exte	Traing coverage	. aryagou ro e gi			
2. Select Maximum Limit					3. Select Coverage					
\$ 60,000.00 \$ 110,000.00 \$ 550,000.00 \$ 1,100,000.00				√ Travel To Exclude US						
\$ 2,000,000.00				Travel To Include US						
(NOTE: \$ 50,000 Maximum Limit 70-79, \$	12,000 Maximum L	imit 80+)								
4. Please list names of all persons to be (Last Name, First Name, MI)	Insured.	Date of Birth M/D/Y		ex I/F	Daily Rate	Number of Days	Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total	
YAGOD AL		11/13/1998	Male		1.30 x	364 =	473.20 x	1.00 = Total (A		
5. Please Select a Deductible				6. Plea	ase enter inform	ation from Sect	ions 4 and 5			
Deductible Rate Factor	Deductible Rate Factor			Premium Total (A) from Section 4: 473.20						
√ \$ 0.00 1.25	\$ 100.00			Deductible Rate Factor from Section 5: x 1.25						
\$ 250.00 1.00	\$ 500.00	0.90		Enter Total Here: = 591.50						
\$ 1,000.00 0.80 \$ 2,500.00 0.70				Optional Express Mail: US \$25 NON-US \$35						
						тс	TAL AMOUNT	DUE:	\$ 591.50	
7. Payment Method Cheque/Money Order Visa Card Master Card Discover Card				All payments must be made in U.S. dollars. Please make checks and money orders payable to Azimuth Risk Solutions. If paying by creditcard, I authorize Azimuth Risk Solutions to debit my Visa card, MasterCard, American Express card, or Discover card account for the totalamount due as specified on the Application. Coverage purchased by credit card is subject to validation and acceptance by the credit cardcompany. I understand that coverage will not be effective if the credit card company denies the charge. Note: On American Expresscards, the CSC is a 4 digit number printed on the front above the account number. On all other cards, it is a 3 digit value printed on thesignature panel on the back of the card immediately following the account number, or a portion of the account number.						
Credit Card Number:				Expiration Date: Card Security Code (CSC):						
Billing Address: 18 Mill Street, Mars Hill , Maine, Maine, United States, 04758				Name a	as it appears on o	ard:	Signature:	Signature:		
8. Agent/Broker Information										
Agent/Broker Name: Cynthia Posner Smolin				Azimuth Agent ID: 62a11336						
Company Name & Address: Cynthia Posner Smolin				Calle 85 #10-46,(302) Bogota ,						
Phone: +571-6066869	Fax: +571-6066870 x.104				cposner@pi- esdeseguros.com	ı	Website:			
I hereby apply for membership in the certain Underwriters at Lloyd's. I und sudden and unexpected event while certification Requirement and otherre online and will not be effective unless summary of benefits and that I may ot at Lloyd's, as underwriter of the plan approved, non-admitted insurer in all snot be made against any state guarar of the Applicant. If signed by a repre Applicant, the undersigned warrants hauthority of the signer to so actand bin	erstand that the instraveling outside is strictions and exclusuch transaction is obtain a complete co, is solely liable fostates of the United that fund. I understail essentative of the Ais/her capacity to si	surance applied my Home Cour isions. I unders confirmed in w py of the Maste rithe coverage a States except I and and agree th pplicant, the un	d for is ntry. I stand the riting be repolicy and be lillinois anat the ndersig	not a gundersinat if I a by Azimiy upon in nefits pand Kerinsuran	general healthir tand this insura am eligible for a uth Risk Solution request to Azimorovided under thucky where those agent/broke arrantshis/her communications agent/broke agent/b	asurance policy ance contains an extension cons. I understanuth Risk Soluti this insurance ey are admitte r, if any, assistapacity to so	/, but is intend a Pre-existing of this insurance and that theinfor ons. I understa I understand d. As such, cla ting with this A act. If signed	ed for use in Condition exe, it may only mation contained that Certa that Lloyd's dims under this pplication is a guardian of	the event of a clusion, a Pre- be transacted ned herein is a in Underwriters operates as an insurancemay representative or proxy of the	
SignatureX:				Date	(M/D/Y):					