## The Beacon Series Application

1. Please print legibly. Complete SECTIONS 1 - 7 and sign the application														
Last Name: Macedo Ramirez					First Name: Alonso					MI:				
Complete MailingAddress for correspondence: Paseo de la Reforma No.265 Col. Cuauhtemoc CDMX, Distrito Federal Postal Code: 06500 Mexico					Country of Citizenship: Mexico				Start Date of Coverage (M/D/Y): 06/02/2024					
Daytime Telephone: 525550802000					Countries to be visited: 1. United States 3					Date of Departure(M/D/Y): 06/02/2024				
<b>Note:</b> The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.					2 4					End Date of Coverage ( M/D/Y): 06/08/2024				
					Primary Applicant's Passport, SSN, or Driver's License #: G27578817									
If you require your Fulfillment Kit to be					Please provide an E-mail address. Email is required for extending coverage: almazane@state.gov									
mailed to you, please check here:														
2. Select Maximum Limit	3. Select Coverage													
✓ \$ 60,000.00					Travel To Exclude US									
\$ 2,000,000.00	✓ Travel To Include US													
(NOTE: \$ 50,000 Maximum Limit 70-79, \$ 12,000 Maximum Limit 80+)														
4. Please list names of all persons to be Insured. (Last Name, First Name, MI)				ex Daily Number /F Rate Days				Premium Sp Sub Total Rider		tional oorts r Enter 1.3	Premium Total			
Macedo Ramirez Alonso		02/18/1991	Male		1.81 x		7 =		12.67 x		1.00 =	12.67		
											Total (A)	\$ 12.67		
5. Please Select a Deductible	6. Please enter information from Sections 4 and 5													
	uctible	Rate Fac	tor		Premium Total (A)							12.67		
√ \$ 0.00 1.25	\$100.00			Deductible Rate Factor from Section						_	_			
\$250.00				Enter Total Here: = 15.84								= 15.84		
\$ 1,000.00 0.80 \$ 2,500.00 0.70				Optional Express Mail: US \$25 NON-US \$35										
					TOTAL AMOUNT DUE: \$ 15.84									
7. Payment Method Cheque/Money Order Visa Card American Express 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 card company. 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 :					Name as it appears on card:					Signature:				
8. Agent/Broker Information														
Agent/Broker Name: ARS Default					Azimuth Agent ID: azimuth									
Company Name & Address: Azimuth Risk Solutions				8520 Allison Pointe Blvd.,Suite 220 Indianapolis , Indiana										
Phone: 888-201-8850 Fax:	e: 888-201-8850 Fax: 888-201-8851 or 317-423-9620			Email: service@azimuthrisk.com					Website:					
I hereby apply for membership in the Beacon/ Axis Series Group Insurance Trust (Anguilla), and for the insurance provided to Participating Member(s) by certain Underwriters at Lloyd's. I understand that the insurance applied for is not a general healthinsurance 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 certification Requirement and otherrestrictions and exclusions. I understand that if I am eligible for an extension of this insurance, it may only be transacted online and will not be effective unless such transaction is confirmed in writing by Azimuth Risk Solutions. I understand that theinformation contained herein is a summary of benefits and that I may obtain a complete copy of the Master Policy upon request to Azimuth Risk Solutions. I understand that Certain Underwriters at Lloyd's, as underwriter of the plan, is solely liable forthe coverage and benefits provided under this 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 insurancemay 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. By acceptance of coverage and/or submission of any claim for benefits, the Applicant.														
SignatureX:					Date (M/D/Y):									