The Beacon Series Application

Please print legibly. Complete SECTIONS 1 - 7 and sign the application									hat. E		
Last Name: Gutierrez Gasco Complete MailingAddress for correspondence: PO BOX 9000 BROWNSVILLE,					First Name: Miguel Country of				MI: F Start Date of		
Texas					Citizenship: Mexico			Coverage (I	Coverage (M/D/Y):		
Postal Code: 78520 United States Daytime Telephone: 525550802770					Countries to be visited:				04/08/2024 Date of Departure(M/D/Y):		
· ·					1. United States 3 2 4			04/08/2024			
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.					Z. 7.			04/13/2024	End Date of Coverage (M/D/Y): 04/13/2024		
						Primary Applicant's Passport, SSN, or Driver's License #: G40253213					
If you require your Fulfillment Kit to be					Please provide an E-mail address.						
mailed to you, please check here:						Email is required for extending coverage: jimenezc@state.gov					
2. Select Maximum Limit						3. Select Coverage					
√ \$60,000.00					Travel To Exclude US						
\$ 2,000,000.00						√ Travel To Include US					
		\$ 12,000 Maximum L	imit 80+)								
4. Please list names of all persons to be Insured. Date of Birth					ex I/F	Daily Rate	Number of Days	Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total	
Gutierrez Gasco Mig	juel F		11/02/1978	Male		2.70 x	6 =	16.20 x	-	= 16.20	
									Total (A	\$ 16.20	
5. Please Select a Deductible 6. Please enter information from Sections 4 and 5											
Deductible	e Rate Factor Deductible Rate Factor			ctor	Premium Total (A) from Section 4: 16.20						
\$ 0.00	\$ 0.00 1.25				Deductible Rate Factor from Section 5: x 1.25						
\$ 250.00	\$ 250.00 1.00 \$ 500.00 0.90				Enter Total Here: = 20.25						
\$ 1,000.00 0.80 \$ 2,500.00 0.70					Optional Express Mail: US \$25 NON-US \$35						
							тс	TAL AMOUNT	DUE:	\$ 20.25	
7. Payment Method Cheque/Money Order Visa Card Master 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 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 Secur	Card Security Code (CSC):		
Billing Address:					Name as it appears on card:			Signature:	Signature:		
8. Agent/Broker Info	ormation										
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: 888-201-8851 or 317-423-9620					Email: service@azimuthrisk.com Website:						
certain Underwrite sudden and unexy certification Requir online and will not summary of benefi at Lloyd's, as und approved, non-adn not be made again of the Applicant. It	rs at Lloyd's. I un pected event whill rement and othern be effective unles ts and that I may of erwriter of the pla nitted insurer in all nest any state guara f signed by a rep ersigned warrants	ne Beacon/ Axis Ser derstand that the inse e traveling outside restrictions and exclus s such transaction is obtain a complete copin, is solely liable for states of the United anty fund. I understar resentative of the A his/her capacity to so ind the Applicant.	surance applied my Home Cou isions. I underst confirmed in v py of the Master the coverage States except and and agree to pplicant, the u	d for is untry. I stand the writing be and be Illinois at the undersign.	not a gunders at if I a py Azim y upon enefits pand Kerinsurar	general healthir tand this insuration this insuration eligible for uth Risk Solution request to Azim provided under intucky where those agent/brokearrantshis/her control the second second in the sec	nsurance policy ance contains an extension cons. I understa auth Risk Soluti this insurance ey are admitte or, if any, assista pacity to so	n, but is intended a Pre-existing of this insurance of the their one. I understand d. As such, claing with this A act. If signed	ded for use in ground to grow the ground to grow the grown and that Certa I that Lloyd's aims under this publication is a guardian	I the event of a xclusion, a Pre y be transacted ined herein is a ain Underwriters operates as an s insurancemay a representative or proxy of the	
SignatureX:					Date (M/D/Y):						