The Beacon Series Application

1. Please print legibly. Co	-	IONS 1 - 7 and sign th	ne application								
Last Name: Milian Fernandez					First Name: Claudia del Socorro				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): 01/28/2024		
Daytime Telephone: 525550802000					Countries to be visited:				Date of Departure(M/D/Y):		
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.					1. United States 3 2 4			End Date of	01/28/2024 End Date of Coverage (M/D/Y): 02/03/2024		
on the Application, in not otherwise indicated.					Primary Applicant's Passport,						
If you require your Fulfillment Kit to be					SSN, or Driver's License #: G31694950 Please provide an E-mail address.						
mailed to you, please check here:					Email is required for extending coverage: almazane@state.gov						
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 Maximur	m I imit 70-79	\$ 12 000 Maximum Li	imit 80±)		٠	Traver to mora	uc 00				
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	Premium Total	
Milian Fernandez Claudia	del Socorro		06/16/1970	Female	9	3.96 x	7 =	27.72 x	1.3	= 27.72	
									Total (A	\$ 27.72	
5. Please Select a Deductible 6. Please enter information from Sections 4 and 5											
Deductible	Rate Factor	te Factor Deductible Rate Factor			Premium Total (A) from Section 4: 27.72						
√ \$ 0.00	\$ 0.00 1.25 \$ 100.00 1.10				Deductible Rate Factor from Section 5: x 1.25						
\$ 250.00	\$ 250.00 1.00				Enter Total Here: = 34.65						
\$ 1,000.00 0.80 \$ 2,500.00 0.70					Optional Express Mail: US \$25 NON-US \$35						
							тс	TAL AMOUNT	DUE:	\$ 34.65	
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 Informati	ion										
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:						
I hereby apply for mem certain Underwriters at sudden and unexpecte certification Requiremer online and will not be ef summary of benefits and at Lloyd's, as underwrit approved, non-admitted not be made against an of the Applicant. If sign Applicant, the undersign authority of the signer to	Lloyd's. I und event while he and other fective unless d that I may cler of the platinsurer in all ly state guaraned by a replaced warrants.	derstand that the inset raveling outside restrictions and excluses such transaction is obtain a complete cope, is solely liable for states of the United introduced in the American form of the Ahis/her capacity to so	surance applied my Home Countries I understoons. I understoons I underst	d for is untry. I stand the writing be and be Illinois a that the undersign.	not a gundershat if I aby Azimiy upon in the fits pand Kerinsuran gned wa	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	/, but is intend a Pre-existing of this insurand and that theinfo ons. I understand d. As such, cla ting with this A act. If signed	ded for use in condition exe, it may only read on the contain and that Certa that Lloyd's aims under this pplication is a signardian	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):						