The Beacon Series Application

1. Please print legibly. Complete SECTION	ONS 1 - 7 and sign th	ne application								
Last Name: Romero Servin				First Name: Luz Viviana				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): 04/03/2024		
Daytime Telephone: 525550802000				Countries to be visited: 1. United States 3			Date of Dep 04/03/2024	Date of Departure(M/D/Y): 04/03/2024		
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.				2 4			End Date of 04/05/2024	End Date of Coverage (M/D/Y): 04/05/2024		
				Primary Applicant's Passport, SSN, or Driver's License #: G38022132						
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 L	imit 80+)								
4. Please list names of all persons to be (Last Name, First Name, MI)	Date of Birth M/D/Y		ex Daily Number of I/F Rate Days		Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total			
Romero Servin Luz Viviana		08/05/1972	Female	Э	3.96 x	5 =	19.80 x	1.00	= 19.80	
								Total (A	\$ 19.80	
5. Please Select a Deductible	6. Please enter information from Sections 4 and 5									
Deductible Rate Factor	Deductible	Rate Fac	ctor		Premium Total (A) from Section 4: 19.80					
\$ 0.00	\$ 100.00			Deductible Rate Factor from Section 5: x 1.25						
\$ 250.00 1.00	\$ 500.00	0.90		Enter Total Here: = 24.75						
\$ 1,000.00 0.80 \$ 2,500.00 0.70				Optional Express Mail: US \$25 NON-US \$35						
						тс	TAL AMOUNT	DUE:	\$ 24.75	
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:				Name as it appears on card:			Signature:	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: 888-201-8851 or 317-423-9620				Email: service@azimuthrisk.com 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 of 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 reprivapplicant, the undersigned warrants hauthority of the signer to so actand bir	erstand that the instraveling outside restrictions and exclusuch transaction is otain a complete cope, is solely liable for states of the United that fund. I understart essentative of the Apis/her capacity to so	surance appliemy Home Cousions. I understoons of the Master the coverage States except and and agree the pplicant, the understood of the Master the coverage states except and and agree the pplicant, the understood of the Master the	d for is untry. I stand the writing be and be Illinois at the undersign.	not a gundershat if I a ay Azimiy upon in nefits pand Kerinsuran	general healthir tand this insura am eligible for a uth Risk Solutic request to Azim provided under nucky where thace agent/broke arrantshis/her c	asurance policy ance contains an extension c ins. I understa uth Risk Soluti this insurance ey are admitte r, if any, assis apacity to so	y, but is intend a Pre-existing of this insurance nd that theinfortions. I understate. I understand d. As such, cla ting with this A act. If signed	led for use in Condition ee, it may onlow that Certa that Lloyd's ims under thi pplication is a guardian	I the event of a xclusion, a Pre- y be transacted ined herein is a a in Underwriters operates as an s insurancemay a representative or proxy of the	
SignatureX:				Date (M/D/Y):						