The Beacon Series Application

1. Please print legibly. Complete SECTIONS 1 - 7 and sign the application

Last Name: Sandoval Sanchez	First Name: Ana Lilia	MI: ------
Complete MailingAddress for correspondence: Paseo de la Reforma 305 ------ Ciudad de Mexico, Distrito Federal Postal Code: 06500 Mexico	Country of Citizenship: Mexico	Start Date of Coverage (M/D/Y): 04/21/2024
Daytime Telephone: +5255 5080 2000	Countries to be visited: 1. United States 3. ------ 2. ------ 4. ------	Date of Departure(M/D/Y): 04/21/2024
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.		End Date of Coverage (M/D/Y): 04/26/2024
	Primary Applicant's Passport, SSN, or Driver's License #: N11219291	
If you require your Fulfillment Kit to be mailed to you, please check here: ☐	Please provide an E-mail address. Email is required for extending coverage: amadorp@state.gov	

2. Select Maximum Limit

☑ $ 60,000.00   ☐ $ 110,000.00   ☐ $ 550,000.00   ☐ $ 1,100,000.00

☐ $ 2,000,000.00

(NOTE: $ 50,000 Maximum Limit 70-79, $ 12,000 Maximum Limit 80+)

3. Select Coverage

☐ Travel To Exclude US

☑ Travel To Include US

4. Please list names of all persons to be Insured.

Please list names of all persons to be Insured. (Last Name, First Name, MI)	Date of Birth M/D/Y	Sex M/F	Daily Rate	Number of Days	Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total
Sandoval Sanchez Ana Lilia ------	11/17/1976	Female	2.70 x	6 =	16.20 x	1.00 =	16.20
						Total (A)	$ 16.20

5. Please Select a Deductible

Deductible	Rate Factor	Deductible	Rate Factor
☑ $ 0.00	1.25	☐ $ 100.00	1.10
☐ $ 250.00	1.00	☐ $ 500.00	0.90
☐ $ 1,000.00	0.80	☐ $ 2,500.00	0.70

6. Please enter information from Sections 4 and 5

Premium Total (A) from Section 4:	16.20
Deductible Rate Factor from Section 5:	x 1.25
Enter Total Here:	= 20.25
Optional Express Mail: ☐ US $25 ☐ NON-US $35	+ ------
TOTAL AMOUNT DUE:	**$ 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 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: 888-201-8851 or 317-423-9620	Email: service@azimuthrisk.com Website:

SignatureX: Date (M/D/Y):