The Beacon Series Application

1. Please print legibly. Complete SECTIONS 1 - 7 and sign th	e application	-	AND MEN					
Last Name: Enoch			st Name: NFN		MI:			
Complete MailingAddress for correspondence: 474 Island Street Stoughton, Massachusetts Postal Code: 02072 United States			untry of zenship: United State		Start Date of Coverage (M/D/Y): 03/30/2024			
Daytime Telephone: 8573917665			untries to be visited: rance 3	Date of Depa 04/01/2024	Date of Departure(M/D/Y): 04/01/2024			
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.			4	End Date of 03/28/2025	End Date of Coverage (M/D/Y): 03/28/2025			
			Primary Applicant's Passport, SSN, or Driver's License #: A26397103					
If you require your Fulfillment Kit to be			Please provide an E-mail address. Email is required for extending coverage: Enoch@chonecapital.com					
mailed to you, please check here:			'			·		
2. Select Maximum Limit			3. Select Coverage					
\$ 60,000.00 \$ 110,000.00 \$ 550,000.00 \$ 1,100,000.00			√ Travel To Exclude US					
\$ 2,000,000.00			Travel To Include	de US				
(NOTE: \$ 50,000 Maximum Limit 70-79, \$ 12,000 Maximum Lin	mit 80+)							
4. 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	
Enoch NFN	06/21/1981 M	ale	1.65 x	364 =	600.60 x	1.00 = Total (A)		
5. Please Select a Deductible	6. F	6. Please enter information from Sections 4 and 5						
Deductible Rate Factor Deductible	Rate Factor	r		(A) from Section) from Section 4: 600.60			
√ \$ 0.00 1.25	1.10		Dedu	ctor from Section	or from Section 5: x 1.25			
\$ 250.00 1.00 \$ 500.00	0.90		Enter Total Here: = 750.7			= 750.75		
\$1,000.00 0.80 \$2,500.00 0.70			Optional Express Mail: US \$25 NON-US \$35					
				тс	TAL AMOUNT [DUE:	\$ 750.75	
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:			piration Date:		Card Security Code (CSC):			
Billing Address:			me as it appears on c	ard:	Signature:	Signature:		
8. Agent/Broker Information								
Agent/Broker Name: Visitors Insurance			Azimuth Agent ID: 2b8b792a					
Company Name & Address: Community Insurance Agency, Inc.			425 Huehl Rd. Suite# 22-A, Northbrook , Illinois					
Phone: 1-800-344-9540 or 847-897-5120 Fax: 847-897-5130			Email: info@visitorsinsurance.com Website: http://www.visitorsinsurance.com/					
I hereby apply for membership in the Beacon/ Axis Seri certain Underwriters at Lloyd's. I understand that the ins sudden and unexpected event while traveling outside mertification Requirement and otherrestrictions and exclus online and will not be effective unless such transaction is summary of benefits and that I may obtain a complete cop at Lloyd's, as underwriter of the plan, is solely liable for approved, non-admitted insurer in all states of the United on the made against any state guaranty fund. I understand the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so authority of the signer to so actand bind the Applicant.	urance applied for ny Home Countroisions. I understant confirmed in writing of the Master Fathe coverage and States except Illing d and agree that oplicant, the understant policant, the understant policant, the understant policant in the understant policant	or is not y. I undond that if ing by Az Policy upod benefit and the insuersigned	a general healthin lerstand this insurar flam eligible for a zimuth Risk Solution request to Azim ts provided under Kentucky where the urance agent/broked warrantshis/her c	surance policy ince contains in extension of ns. I understain uth Risk Soluti this insurance ey are admitte r, if any, assist apacity to so	/, but is intended a Pre-existing of this insurance and that theinform ons. I understand d. As such, claiting with this Apact. If signed a	ed for use in Condition exits, it may only mation contain that Certain that Lloyd's own under this oplication is a sas guardian o	the event of a clusion, a Pre- be transacted ned herein is a n Underwriters operates as an insurancemay representative or proxy of the	
SignatureX:		Da	ate (M/D/Y):					