The Beacon Series Application

1. Please print legibly. Complete	SECTIONS 1 - 7 and sign to	he application								
Last Name: Macedo Ramirez				First Name: Alonso				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): 02/25/2024		
Daytime Telephone: 525550802000				Countries to be visited: 1. United States 3			Date of Dep 02/25/2024	Date of Departure(M/D/Y): 02/25/2024		
Note: The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.				2 4			End Date of 03/02/2024	End Date of Coverage (M/D/Y): 03/02/2024		
				Primary Applicant's Passport, SSN, or Driver's License #: N10210307						
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 Insured. (Last Name, First Name, MI)		Date of Birth M/D/Y				Number of Days	Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total	
Macedo Ramirez Alonso		02/18/1991	Male		1.81 x	7 =	12.67 x	1.00 Total (<i>A</i>		
5. Please Select a Deductible					6. Please enter information from Sections 4 and 5					
Deductible Rate Fa		Rate Fac	tor	Premium Total (A) from Section 4: 12.67 Deductible Rate Factor from Section 5: x 1.25						
₹ \$ 0.00	\$ 100.00	0.90		Enter Total Here: = 15.84						
\$ 250.00	\$ 500.00	0.70		- · ·						
\$1,000.00 0.80 \$2,500.00 0.70				Optional Express Mail: US \$25 NON-US \$35						
						TC	TAL AMOUNT	DUE:	\$ 15.84	
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 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 certain Underwriters at Lloyd's sudden and unexpected even certification Requirement and online and will not be effective summary of benefits and that I at Lloyd's, as underwriter of the approved, non-admitted insurer not be made against any state of the Applicant. If signed by Applicant, the undersigned war authority of the signer to so act	I understand that the instantial while traveling outside to otherrestrictions and excluunless such transaction is may obtain a complete cone plan, is solely liable for in all states of the United guaranty fund. I understal a representative of the Arrants his/her capacity to si	surance applied my Home Coul isions. I unders confirmed in w py of the Maste rthe coverage a States except I nd and agree th pplicant, the ui	d for is ntry. I ustand the vriting by and ber allinois anat the indersig	not a gunderstat if I a y Azimu upon u nefits pand Kerinsuran ned wa	general healthing tand this insur- tand this insur- tand this insur- tand eligible for uth Risk Solution request to Azim provided under thucky where the those agent/broke arrantshis/her of the second this contract the	nsurance policy ance contains an extension cons. I understanuth Risk Solution this insurance they are admitteer, if any, assis- capacity to so	y, but is intended a Pre-existing of this insurand that theinforms. I understand d. As such, clating 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 pplication 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):						