## The OverseasCare<sup>™</sup> Visitors Insurance<sup>™</sup> Medical Plan Application

1. Please print legibly. Complete SECTIONS 1 - 7 and sign the application									
Last Name: Phatale				me: Sulabha			MI: P		
Complete Mailing Address for correspondence: 20 Mid River Run Rd Stamford, Connecticut Postal Code: 06902			Country of Citizenship: India				Start Date of Coverage (M/D/Y): 03/18/2024		
Countries to be visited: 1. United States 3. United States 2. United States 4. United States			Daytime Telephone Number(s): 2035507743			Date of Dep 03/18/2024	Date of Departure(M/D/Y): 03/18/2024		
<b>Note:</b> The primary insured will be Beneficiary for spouse & dependent children on this Application, if not otherwise indicated.			·			End Date of 10/18/2024	End Date of Coverage ( M/D/Y): 10/18/2024		
			Primary Applicant's Passport, SSN or Driver's License #: R3571521						
If you require your Fulfillment Kit to be			Please provide an E-mail address. Email is required for extending coverage: ronitm@hotmail.com						
mailed to you, please check here:									
2. Select Coverage Option			3. Select Deductible Option:						
Basic Coverage       ✓       Premier Coverage       Age 80 Plus       US 100       US 250       ✓       US 500									
\$60,000 Benefit \$110,000 Benefit \$55,000 Benefit							Ontional		
4. Please list names of all persons to be Insured. (Last Name, First Name, MI)	Date of Birth M/D/Y		ex I/F	Daily Rate	Number of Days	Premium Sub Total	Optional Sports Rider Enter 1.3	Premium Total	
Phatale Sulabha P	09/27/1950	Female	Э	2.49 x	215 =	535.35 x			
							Total (A)	\$ 535.35	
5. Please Select a Deductible				6. Please enter information from Sections 4 and 5					
Deductible Rate Factor Deductible	tible Rate Factor Deductible Rate Factor			Premium Total (A)			from Section 4: 535.35		
\$100.00 1.10 \$250.00 1.00			Enter Total Here: = 535.35						
✓ \$ 500.00 0.90			Optional Express Mail: US \$25 NON-US + \$35						
				TOTAL AMOUNT DUE: \$535.35					
7. Payment Method Cheque/Money Order Visa 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 credit card, I authorize Azimuth Risk Solutions to debit my Visa card, MasterCard, American Express card, or Discover card account for the total amount due as specified on the Application. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I understand that coverage will not be effective if the credit card company denies the charge. Note: On American Express cards, 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 the signature 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: 20 Mid River Run Rd, Stamford, Connecticut, United States, 06902			Name as it appears on card:			Signature:	Signature:		
8. Agent/Broker Information									
-				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	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 Series Group Insurance Trust (Anguilla)/OverseasCare <sup>™</sup> Visitors Insurance <sup>™</sup> Plan, and for the insurance provided to Participating Member(s) by certain Underwriters at Lloyd's. I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Requirement and other restrictions and exclusions. I understand that if I am eligible for an extension of this insurance, it may only be transacted online and will not be effective unless such transaction is confirmed in writing by Azimuth Risk Solutions. I understand that the information contained herein is a summary of benefits and that I may obtain a complete copy of the Master Policy upon request to Azimuth Risk Solutions. I understand that Certain Underwriters at Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under this insurance. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.									
Signature X:			Date	(M/D/Y):					

THE OVERSEASCARE™ VISITORS INSURANCE™ MEDICAL PLAN APPLICATION

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