The OverseasCare™ Visitors Insurance™ Medical Plan Application

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

Last Name: Sirumamila	First Name: Anantasayana	MI: Prasad
Complete Mailing Address for correspondence: 3139 240th Ave NE ------ Sammamish, Washington Postal Code: 98074 ------	Country of Citizenship: India	Start Date of Coverage (M/D/Y): 04/09/2024
Countries to be visited: 1. United States 3. ------ 2. ------ 4. ------	Daytime Telephone Number(s): 3126263186	Date of Departure(M/D/Y): 04/08/2024
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): 09/21/2024
	Primary Applicant's Passport, SSN or Driver's License #: B6533015	
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: divya82.avula@gmail.com	

2. Select Coverage Option

☑ Basic Coverage ☐ Premier Coverage ☐ Age 80 Plus

$60,000 Benefit $110,000 Benefit $55,000 Benefit

3. Select Deductible Option:

☐ US 100 ☐ US 250 ☑ US 500

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
Sirumamila Anantasayana Prasad	06/18/1950	Male	2.16 x	166 =	358.56 x	1.00 =	358.56
Sirimamilla Rekha Prasad	04/01/1954	Female	2.16 x	166 =	358.56 x	1.00 =	358.56
						Total (A)	$ 717.12

5. Please Select a Deductible

Deductible	Rate Factor	Deductible	Rate Factor
☐ $ 100.00	1.10	☐ $ 250.00	1.00
☑ $ 500.00	0.90		

6. Please enter information from Sections 4 and 5

Premium Total (A) from Section 4:	717.12
Enter Total Here:	= 717.12
Optional Express Mail: ☐ US $25 ☐ NON-US $35	+ ------
TOTAL AMOUNT DUE:	$717.12

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 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 : ------	Name as it appears on card: ------	Signature:

8. Agent/Broker Information

Agent/Broker Name: Visitors Insurance (Community Insurance Agency, Inc.)		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 Series Group Insurance Trust (Anguilla)/OverseasCare™ Visitors Insurance™ 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. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. 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. If signed as guardian or proxy 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):**