The OverseasCare[™] Visitors Insurance[™] Medical Plan Application

| 1. Please print legibly. Complete SECTIONS 1 - 7 and sign the application | | | | | | | | |
|---|-----------------|------------|---|-------------------|----------------------|--|------------------|--|
| Last Name: Mekala | | | First Name: Eswara Vara Prasada Rao MI: | | | | | |
| Complete Mailing Address for correspondence: 935 Matterhorn Court MILPITAS, California Postal Code: 95035 | | | Country of Citizenship: India | | | Start Date of Coverage (M/D/Y): 04/25/2024 | | |
| Countries to be visited: 1. United States 3. United States 2. United States 4. United States | | | Daytime Telephone Number(s): 4085946622 | | | Date of Departure(M/D/Y): 04/25/2024 | | |
| 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): 10/22/2024 | | | | | |
| | | | Primary Applicant's Passport, SSN or Driver's License #: \$0732690 | | | | | |
| 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: mvrajesh1@gmail.com | | | | | |
| 2. Select Coverage Option | | | 3. Select Deductible Option: | | | | | |
| Basic Coverage Premier Coverage Age 80 Plus \$60,000 Benefit \$110,000 Benefit \$55,000 Benefit | | | US 100 US 250 🖌 US 500 | | | | | |
| | of Birth D/Y | Sex M/F | Daily Rate | Number of Days | Premium Sub Total | Optional Sports Rider Enter 1.3 | Premium Total | |
| Mekala Eswara Vara Prasada Rao 08/02/1 | | | 2.11 x | 181 = | 381.91 x | | | |
| Zagabathuni Venkata Subhadra 06/16/1 | 1964 Ferr | ale | 1.74 x | 181 = | 314.94 x | 1.00 = Total (A) | | |
| 5. Please Select a Deductible 6. Please enter information from Sections 4 and 5 | | | | | | | | |
| Deductible Rate Factor Deductible Rate Factor | | | Premium Total (A) from Section 4: 696.85 | | | | | |
| \$ 100.00 1.10 \$ 250.00 1.00 | | | Enter Total Here: = 696.85 | | | | | |
| √ \$ 500.00 0.90 | | | Optional Express Mail: US \$25 NON-US + \$35 | | | | | |
| | | | TOTAL AMOUNT DUE: \$696.85 | | | | | |
| 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: 935 Matterhorn Court, MILPITAS, California, United States, 95035 | | | 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: | 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 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. 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

3