BEACON APPLICATION

Please Print legibly and complete ALL SECTIONS (front and back) of this application. Rates found on brochure back page.

1. Primary applicant information:

Last Name: Useche	First Name: Luis	MI: ------
Complete Mailing Address for all correspondence: Av. Esparia. Conjunto Res. Av. Esparia. Casa N 21 ------	City, State: San Cristobal Tachira	Postal Code: 5001
Country: Venezuela	Passport, SSN, or Drivers License #: N/A	Issuing Country: Venezuela
Requested Effective Date(M/D/Y) : 11/24/2009	Date of Departure(M/D/Y) : 11/24/2009	Date of Return to Home Country(M/D/Y) : 11/28/2009

Please indicate beneficiary for the accidental death benefit.
Note: The Primary Insured will be the Beneficiary for spouse and dependent children on this Application.

Beneficiary for Applicant: (enter below)	Relationship to Applicant: (enter below)
Victoria Useche	Hermana
Please provide an E-mail address below where you would like to receive your electronic Confirmation of Coverage and Fulfillment Kit. **If you require your Fulfillment Kit to be mailed to you, please check here:**	Destination Country(ies): 1. United States 3. ------ 2. ------ 4. ------
Email: codimca@hotmail.com	
Telephone: 58-276-3562040	Country of Citizenship: Venezuela

Please complete the number of whole months you are traveling. If you are traveling less than a whole month, please complete ONLY the number of days you are traveling.If you have a combination of whole months and days, please calculate both in the boxes provided below. **Note: a whole month is considered 30 days.**

2. Please list names of all persons to be Insured. (Last Name, First Name, MI)		Date of Birth M/D/Y	Sex M/F	Age	Monthly Rate	# of months Travel Coverage	Total Monthly Premium	Daily Rate	# of Days	Total Daily Premium
A	Useche Luis ------	05/24/1968	male	41	0 x	0=	0	4.75 x	5=	23.75
B	Pabon Yaklin ------	12/07/1970	female	38	0 x	0=	0	3.25 x	5=	16.25
C	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
D	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
E	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
F	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
G	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
H	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
I	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
J	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
K	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
L	------ ------ ------	------	------	------	------ x	------=	------	------ x	------=	------
If visiting the U.S. will you be located in Florida to work? ☐ Yes ☐ No							Total (A) (enter above)0			Total (B) (enter above)40

3. Please select a deductible.	*Deductible Amount	*Rate Factor	*Optional Sports Rider Rate Factor
Selected deductible and applicable rate amount.	$0.00	1.25	1.2

4. Please enter correct amounts from Sections 2 and 3.

(A) Monthly Premium Total	From Total (A) in Section 2	0
(B) Daily Premium Total	From Total (B) in Section 2	+ 40
Total Base Premium	enter amount here:	= 40
*Deductible Rate Factor	(*Rate Factor) in Section 3	x 1.25
Enter Total Here	enter amount here:	= 50
To purchase the **Optional Sports Rider** check: No	enter 1.2 here:	x 1
Enter total here	enter amount here:	= 50
Optional express mail ☐ US $25 ☐ NON-US $35	enter amount here:	+ 0
TOTAL AMOUNT DUE	enter amount here:	50

5. Method of Payment

☐ Check (annual only) ☐ Money Order (annual only) ☐ 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.

Billing Address: Av. Esparia. Conjunto Res. Av. Esparia. Casa N 21	City, State: San Cristobal Tachira	Country: Venezuela	Postal Code: 5001
Name as it appears on card: Olga M. de Murillo	Credit Card Number: XXXXXXXXXXXX5979	Expiration Date (M/Y): 07/2010	
Daytime Phone Number: 58-276-3562040	Signature:		

6. Agent/Broker Information

Azimuth Agent/Broker Number: 0d9f4ec5	Agent/Broker Name: Kuniko Kessler	
Company Name: Legend Travelers		
Street Address: SF Nikko Building,3-2-11 Minamihonmachi		
City: Osaka	State/Postal Code: Chuo-ku 541-0054	
Phone: +81-6-6281-0878	Fax: +81-6-6281-8622	Mobile:
Email: info@legendtravelers.com		
Website: http://www.legendtravelers.com/		
Agent/Broker Signature:		

CANCELLATION POLICY: All cancellation requests must be submitted in writing to Azimuth Risk Solutions. To be eligible for a full refund, the request must be received before your requested effective date. Cancellation Requests received after the requested effective date will be subject to the following:

a) a $25 cancellation fee; and
b) only the unused portion of the premium cost will be refunded; and
c) no claims to be eligible for premium refund

6. SUBSCRIPTION: I hereby apply for membership in the Beacon/ Axis eries Group Insurance Trust (Anguilla), and for the insurance provided to articipating 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, LLC. 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, LLC. 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

ACKNOWLEDGEMENT I (we) understand and agree that: (i) the insurance agent/broker soliciting, assigned to or assisting with this Application is the representative of applicant(s), (ii) this insurance does not provide benefits for any injury, illness, sickness, disease, or other physical, medical, mental or nervous condition, disorder or ailment that, with reasonable medical certainty, existed at the time of application or at any time during the three years prior to the effective date and time of this insurance, including any subsequent, chronic or recurring complications or consequences related thereto or arising there from, whether or not previously manifested or symptomatic, diagnosed, treated, or disclosed prior to the effective date (a "pre-existing condition"), and that all charges and/or claims for pre-existing conditions will be excluded from coverage under this insurance, (iii) the subjects of insurance applied for are not intended or considered by the applicant(s), the Company or ARS to be resident, located, or expressly to be performed in any particular state of the United States, and (iv) the Company, as carrier and underwriter of the plan, is solely liable for the coverages and benefits to be provided under the insurance contract.

MEDICAL RELEASE I (we) hereby authorize any doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policyholder, employee or benefit plan administrator having information as to my (our) care, advice, treatment, diagnosis or prognosis for any physical or mental condition, or financial and employment status, to provide such information to ARS and/or the Company. CERTIFICATION I (we) hereby certify, represent and warrant that : (i) I (we) have read the foregoing statements and the brochure or that they have been read to me (us), and I (we) understand them, (ii) I am (we are) eligible to participate in the insurance program applied for as a traveler for whom domestic U.S. health care coverage is unavailable, (iii) I am (we are) currently in good health and have not been diagnosed with, sought consultation or been treated for, and have not experienced manifestation or symptoms of and do not suffer from any pre-existing or other medical condition which I (we) foresee may require treatment during this insurance or for which I (we) intend to claim under this insurance. If signed as guardian or proxy of the applicant, the signer warrants their authority and capacity to so act and to bind the applicant. 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 applicant.

Payment must be made for the total number of months you want coverage. All payments must be made in U.S.D. and drawn on U.S. banks.

Signature X: _____

Date (M/D/Y): _____

55 Monument Circle,#128
Indianapolis, Indiana 46208

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Fax; 317-423-9620/888-201-8851

Email: Service@azimuthrisk.com
Website: www.azimuthrisk.com