

HealthCare Global Application #5167 - D.O.I.

FAX completed application to 410-836-7441

Please call (800) 643-4675 between 9:00 a.m.-5:00 p.m. EST for telephone assistance.

First Name _____ Middle Initial _____
 Last Name _____
 Address _____
 Home Telephone _____ Work Telephone _____
 Destination Country/territory _____
 Departure Date _____ Number of Weeks of Insurance Requested _____
 Nationality of Applicant _____
 Passport No. _____ Date of Birth (maximum age 70) _____
 Person to be contacted in the event of an emergency: _____
 Name () () _____
 Home Telephone _____ Work Telephone _____
 Relationship _____
 Payment: Check payable in U.S. funds, drawn on a U.S. bank, and made payable to Weillach & Company, Inc.
 VISA MasterCard American Express
 Card Number _____
 Expiration Date _____
 Name on Credit Card _____

Required Coverage
 \$100,000 Medical Expense Benefits
 \$100 Deductible = \$18/week \$500 Deductible = \$15/week
 \$1,000 Deductible = \$12/week

\$ _____ x _____ = \$ _____
 Cost per Week _____ Weeks _____
(minimum 2 weeks) Number of Persons to be Insured _____ Premium _____

Optional Coverage
Trip Cancellation and Curtailment Benefit
 (\$500 minimum; \$5,000 maximum)
 This coverage is available only if purchased at least 10 days before the Departure Date.
 Cost per Person: .05 x the coverage requested

Coverage Requested _____ x .05 = \$ _____
 Number of Persons to be Insured _____ Premium _____

Optional Coverage
\$100,000 Accidental Death & Dismemberment Benefit
 Cost per Person: \$3,000/week, 2 week minimum - 26 week maximum

\$3,000 x _____ = \$ _____
(minimum 2 weeks) Weeks _____
 Number of Persons to be Insured _____ Premium _____

Name of Beneficiary _____
 Total Amount Due = \$ _____

Declaration of Applicant
 I hereby apply to purchase the insurance. I declare to the best of my knowledge and belief that the information given in this application is true and complete. I acknowledge on behalf of the party to be insured that benefits will not apply to treatment arising from pre-existing medical conditions. It is agreed that this declaration and the information given herein shall form the basis of the contract between the Insured Person and the Company. Further, I hereby subscribe to the International Seafarers Insurance Trust and acknowledge enrolling in this group coverage for which I am eligible under the contract issued by the Company.

Signature of Applicant _____
 my email address _____
 Date _____

CHAMPION INSURANCE ADVANTAGE, LTD.
 P. O. Box 1060
 Bel Air MD 21014-7050