How Do I Apply?

VISIT® Travel & Medical Insurance Program Application

INSTRUCTIONS: Please complete all information on the following application. Incomplete applications may cause a delay in processing your application. Please print clearly.

Please print clearly.

Name: ______________________________________

Address: ____________________________________
(Please indicate an address in the US)

City: ______________ State: ________ Zip: ________

Home Country: _______________________________

Date of Birth: ______________ Gender: __________

Home Tel (___) ________ Work Tel (____) __________

E-Mail Address: ______________________________

Passport Number: _____________________________

VISA Status: J1 F1 J2 F2 Other: _____________

Policy Effective: _____________ Renewal: Yes / No

Policy Expiration Date: ____________________

No. of Coverage Days: __________________
(Count first and last day of coverage.)

Type of Insurance Plan: ○**ECON100** ○**ECON250** ○**STD100** ○**STD250** ○**SPR100** ○**SPR250** ○ **PLT100** ○**PLT250** ○**E^{PLUS}** ○**E^{PLUS} Hazardous**
Primary Destination: ___________________________

Family Members to be covered on this policy (name, date of birth, relationship): Premiums are per/person.

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Emergency Contact Name & Telephone No.:

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Beneficiary: __________________________________

Relationship to Applicant: _______________________

Beneficiary's Address: _________________________

Maximum policy term is 12 months, but you may re-enroll for successive terms, as desired. Applicant must meet application criteria and all conditions and pre-existing exclusions apply.

These rates are for persons traveling abroad and their family members traveling with them. Please review the plan overviews carefully prior to purchasing the policy.
Please call 1-800-247-5575 if you have any questions.

Cancellation Policy. All premiums are fully earned upon Application, and are Non-Refundable. Please apply only for the term of coverage you need, and re-apply as necessary as your plans may change.

Payment Total for All Applicants:$ ____________
Premiums are Per Person.
SELECT PAYMENT METHOD:
CHECK or MONEY ORDER (Payable to **VISIT**)
○MasterCard ○VISA ○American Express

Card Number: ________________________________

Expiration Date (month/year): ____________________

Security Code: _________________

Billing Address: _______________________________

Print Name as it appears on card:

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FRAUD ADVISORY: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud. Insurance fraud may include deliberate misuse of coverage verification during University registration.

APPLICANT STATEMENT: I have read the above application, fraud advisory, and any attachments. I declare that the information provided in them is true, complete and correct to the best of my knowledge and belief. This information is being offered to the company as an inducement to issue the policy for which I am applying.

Signature of Applicant Date

_____________________________ __________

MAIL the Completed Application & Premium to:

VISIT® Travel & Medical Insurance Program
PO Box 210, Mount Vernon, VA 22121
Enroll by Phone: 1-800-247-5575
Enroll by Fax: 1-703-991-9164
Enroll Online: www.visitinsurance.com