VisitorSecure™ Application for Insurance
Tokio Marine HCC Medical Insurance Services Group
Lloyd's Coverholder

Personal Details Please provide the following details for all individuals to be covered. Missing or illegible information will delay processing.

Name (First and Last)	Date of Birth (MM/DD/YY)	Citizenship	Home Country	Daily Premium
Primary				1A
Spouse				2A
Child 1				3A
Child 2				4A

Complete Mailing Address

E-mail Address **Phone Number**

Select a Plan Level Plan A Plan B Plan C Plan D

Select a Deductible $0 $50 $100 $200

Date of Departure from Home Country	Date of Return to Home Country	Requested Effective Date
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

Beneficiary & Relationship

Destination(s)

Subtotals (add lines 1 through 4 above)	A	
Trip Duration (# of days)	B	
Multiply line A by line B	C	
OPTIONAL Express Delivery Charge (If desired, choose only one option) — US Delivery Enter $20.00	D	
Non-US Delivery Enter $30.00	E	
Sub Total Amount Due (add lines C through E)	F	
Florida Surplus (Tax): Traveling to Florida to work? Yes No / Not traveling to Florida — If yes, multiply Line F total by 1.0515	G	
Total Amount Due (add lines F and G)	H	

Payment Information Check/Money Order* (Single Up-Front Payment Only) MasterCard VISA Discover American Express

Credit Card Number | Exp Date

Name on Card | Phone #

Billing Address

City | State | Zip

Cardholder Signature | Date

***Payment by Check or Money Order:** Checks and Money Orders should be made payable, in US dollars, to HCC Medical Insurance Services. Please send Check or Money Order along with this Application via mail or courier to: HCC Medical Insurance Services * 15748 Collection Center Dr. * Chicago, IL 60693-0157

Payment by credit card: I authorize Tokio Marine HCC Medical Insurance Services Group to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of Application or prior to the Effective Date of Coverage.

Authorization

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda and for the insurance provided to members by 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-notification Penalty and other restrictions and exclusions. I understand that if I am eligible for Extensions and Renewals of this insurance that they may only be transacted online and will not be effective unless such transaction is confirmed in writing by Tokio Marine HCC Medical Insurance Services Group, and I understand that Extensions may be transacted after my Effective Date and Renewals may be transacted only within the thirty (30) days immediately preceding my current coverage expiration date. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to Tokio Marine HCC Medical Insurance Services Group. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the 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.

Applicant Signature | Date | Spouse Signature | Date

FOR PRODUCER USE ONLY

Producer ID Number: 99106 www.VisitorsInsurance.com

Producer Name: Ramesh Patel

Company Name & Address: Community Insurance Agency, Inc.
425 Huehl Road, Suite 22-A
Northbrook, IL 60062

Telephone: 1-800-344-9540 / 1-847-897-5120

Fax: 1-847-897-5130

Signature:

E-Mail Address: info@visitorsinsurance.com