How Do I Apply?

Apply Online at www.visitinsurance.com or Complete this Application

VISIT® Travel & Medical Insurance Application

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

Name: ______________________________________

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

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 Date: _______________________

Policy Expiration Date: _______________________

Number of Coverage Days: ________ Renewal: Yes / No
(Include the first and last day of coverage)

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

Primary Destination: _________________________

Name of the University or College in which you are enrolled: (please complete if you are a student):

____

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.:

____

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

Credit Card Number: _________________________

Expiration Date (month/year): _________________

Security Code: ______________

Billing Address: ___________________________

Print Name as it appears on your Credit 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 at www.visitinsurance.com