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: **AB CD E S****

Primary Destination: _____

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

_____

_____

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, **69 years of age and younger.** Additional coverage is available for persons 70-80 years of age. Please call 1-800-247-5575 for premium rates.

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.
***** Plan S must be J1 or F1 VISA ages 17-26 only.***

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:
_____

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