

LIAISON[®] International Application – 2004

Official Use Only: Cert # _____ Processed _____ Eff. Date _____ Agent: 1009-www.otis123.com

Applicant Information

Last Name: _____
 First Name: _____ M.I. _____
 Country of Permanent, fixed Residence (Home Country) _____
 Passport Number / Country: _____
 Departure Date from your Home Country? (MM/DD/YY) ____ / ____ / ____
 AD&D Beneficiary: _____ Relationship: _____
 (Accidental Death & Dismemberment)

Address of Correspondence

(where ID card is to be sent)

Name: _____
 Address: _____
 City: _____ State: _____
 Postal Code: _____ Country: _____
 Work Phone: () _____ Home Phone: () _____
 Email: _____
 Previously insured by SRI? _____ ID Number: _____
 When would you like coverage to begin? (MM/DD/YY) ____ / ____ / ____
 Destination?: _____ Length of Trip?: _____
 What is your expected return date? (MM/DD/YY) ____ / ____ / ____

Please note: The minimum period of coverage is 7 days, the maximum is 12 months (please see Continuing Coverage Option). Coverage must be purchased in increments of no less than 7 days. Coverage cannot begin until your departure from your Home Country, nor will coverage begin until SRI receives and accepts your application and correct payment.

Coverage Specifics

Are you traveling: To the United States or
 Outside the United States
 Policy Maximum: \$50,000 \$100,000 \$500,000
 \$1,000,000
 Deductible:

<u>Option</u>	<u>Factor</u>
<input type="checkbox"/> \$100	1.10
<input type="checkbox"/> \$250	1.00
<input type="checkbox"/> \$500	.90
<input type="checkbox"/> \$1000	.80
<input type="checkbox"/> \$2500	.70

 Continuing
 Coverage Option: No Yes (must buy at least 3 months)
 Coverage Option: Hazardous Sport Coverage (1.15)

Calculating Your Plan Cost

(please complete entire section)

	Date of Birth MM/DD/YY	Monthly Rate	Daily Rate
Applicant: _____	__ / __ / __		
Spouse: _____	__ / __ / __		
Child: _____	__ / __ / __		
Child: _____	__ / __ / __		
Child: _____	__ / __ / __		
Total:		\$	\$

Minimum period of coverage is 7 days

Multiply Monthly Rate Total by number of months:	X	
Monthly Total [A]:		\$
Multiply Daily Rate Total by number of days:	X	
Daily Total [B]:		\$
Total of [A] and [B]:		\$
Multiply by deductible factor:	X	
Total:		\$
Multiply coverage Option Factor: (if applicable)	X	
Total Payment Enclosed:		\$

Method of Payment

Check Money Order MasterCard Visa Discover
 American Express

Card Number: _____

Expiration Date: _____ Day Phone: _____

Name on Card: _____

Billing Address: _____

Signature (Required) _____

Make Check or Money Order payable to "SRI". Total Payment for the Full Term of coverage requested must be paid in U.S. dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I declare that I understand the terms and conditions of this product, as outlined in this brochure. I understand that pre-existing conditions, as defined in Exclusion number 1, are excluded. I understand this program is for persons traveling outside their home country.

I hereby subscribe to the American Consumer Insurance Trust and enroll in the group coverage for which I am eligible under the group contract issued by Virginia Surety Company, Inc. (For Special States, it is the Global International Trust by Certain Underwriters at Lloyd's, London).

Signature of Insured or Proxy (Required) _____ Date _____
 (Proxy is someone acting on behalf of the Insured)