

**Enrollment Form for DAY TRIPPER
Group Travel Health Insurance
Apply online: www.overseashealthinsurance.com**

Agent # 9870SS

~ Please complete only one enrollment form per trip ~

Rates: Valid through 7/31/2005
USD)

Displayed Rates are for \$250 Deductible Option (in

**Day Tripper Group International – US Citizens Traveling
Abroad**

Maximum Limit	\$50,000		\$100,000		\$250,000		\$500,000		\$1,000,000	
	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
AGE										
18-29	31.00	1.00	37.00	1.20	38.00	1.30	40.00	1.35	44.00	1.50
30-39	37.00	1.20	43.00	1.40	50.00	1.70	53.00	1.80	58.00	1.90
40-49	59.00	2.00	66.00	2.20	67.00	2.25	68.00	2.30	75.00	2.50
50-59	97.00	3.20	111.00	3.70	112.00	3.70	113.00	3.80	126.00	4.20
60-64	122.00	4.10	132.00	4.40	158.00	5.20	172.00	5.70	191.00	6.40
65-69	152.00	5.10	167.00	5.60	178.00	5.90	185.00	6.20	204.00	6.80
70-79	204.00	6.80	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80+*	463.00	15.40	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	19.00	0.60	23.00	0.80	24.00	0.80	25.00	0.80	26.00	0.90
Child Alone	31.00	1.00	35.00	1.20	37.00	1.30	38.00	1.30	42.00	1.40

*10,000 Maximum Limit

Day Tripper Group America – Non-US Citizens Traveling Outside of Home Country

Maximum Limit	\$50,000		\$100,000		\$250,000		\$500,000		\$1,000,000	
	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily	Monthly	Daily
AGE										
18-29	43.00	1.40	50.00	1.70	58.00	1.90	62.00	2.10	73.00	2.40
30-39	55.00	1.80	66.00	2.20	76.00	2.50	82.00	2.70	95.00	3.20
40-49	84.00	2.80	95.00	3.20	110.00	3.70	123.00	4.10	139.00	4.60
50-59	120.00	4.00	146.00	4.90	160.00	5.40	174.00	5.80	200.00	6.70
60-64	141.00	4.70	193.00	6.40	210.00	7.00	224.00	7.50	250.00	8.30
65-69	179.00	6.00	223.00	7.40	255.00	8.50	271.00	9.00	293.00	9.80
70-79	227.00	7.60	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
80+*	446.00	14.90	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dep. Child	25.00	0.80	29.00	1.00	32.00	1.10	34.00	1.10	38.00	1.30
Child Alone	39.00	1.30	46.00	1.50	51.00	1.70	54.00	1.80	64.00	2.10

*\$10,000 Maximum Limit

Deductible Factor Table		Hazardous Sports Rider Factor: 1.20
DEDUCTIBLE:	FACTOR:	<i>PREMIUMS ARE NON-REFUNDABLE AFTER YOUR EFFECTIVE DATE. IF REQUESTING CANCELLATION, YOU MUST NOTIFY MNUI, IN WRITING, PRIOR TO THE EFFECTIVE DATE FOR A FULL REFUND. OVERNIGHT CHARGES ARE NOT REFUNDABLE.</i>
\$ 0	1.5	
\$100	1.1	
\$250	1.0	
\$500	0.9	
\$1,000	0.8	
\$2,500	0.7	

DAY TRIPPER GROUP APPLICATION

Print all Names as you would like them to appear on your Identification Cards.
Please print clearly and provide complete information.

Name of Sponsoring Organization:		Contact Name:	
COMPLETE Mailing Address for all correspondence:			
Telephone #:	Fax #:	E-mail Address:	
Destination:		Purpose of Trip:	

Names of all individuals to be covered	Deductible: \$			Maximum Benefit: \$				
	Name (Last, First)	Birth Date mm/dd/yy	Country of Citizenship	Effective Date mm/dd/yy	# of Days	x	Daily Rate	=
1.					x		=	
2.					x		=	
3.					x		=	
4.					x		=	
5.					x		=	
6.					x		=	
7.					x		=	
8.					x		=	
Group Subtotal – Total from above and from additional census (if any)								
Multiply Deductible Factor from Deductible Factor Table								
Enter Factor for Hazardous Sports Rider, if Selected (1.2). Otherwise Enter 1.0								
Total Amount Due								

Payment Information

Payment Mode: } Check/Money Order: } Discover Card } MasterCard } VISA } American Express	Credit Card #:	Expiration Date (mm/yy):
Name as it appears on card:	COMPLETE Billing Address:	
Daytime Phone #:	Signature:	
Check or Money Orders should be made payable, in US dollars, to MultiNational Underwriters, Inc. If paying by credit card, I authorize MultiNational Underwriters, Inc. to debit my Discover, VISA, MasterCard or American Express account for the amount specified above. 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.		

The Sponsoring Organization (Sponsor), on behalf of and as authorized agent and proxy for each of the group participants listed on the Application, hereby applies for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton , Bermuda , and for the insurance provided to members by Lloyd's. The Sponsor and all group participants understand that the insurance applied for is not a general health insurance policy, but is intended for use by members in the event of a sudden and unexpected event while traveling outside their Home Country(ies). The Sponsor and all group participants understand this insurance contains a Pre-existing Condition exclusion, a Pre-notification Penalty and other restrictions and exclusions. The Sponsor and all group participants understand that coverage under this insurance is not renewable and successive periods of insurance will require re-satisfaction of the Deductible, Coinsurance, Pre-existing Condition provision, and all other conditions of the insurance following acceptance of a new Application. The Sponsor and all group participants understand that the information contained herein is a summary of the Master Policy and that they may obtain a complete copy of the Master Policy upon request to MultiNational Underwriters, Inc. The Sponsor and all group participants understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. The Sponsor and all group participants 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. The Sponsor and all group participants understand and agree that the insurance agent/broker, if any, assisting with this Application is their representative. If signed by a representative of the Sponsor, the undersigned warrants his/her capacity to so act. If signed as Sponsor, the undersigned warrants his/her authority to so act. By acceptance of coverage and/or submission of any claim for benefits, the each group participant ratifies the authority of the signer to so act and bind the group participant.

Signature of Sponsor:	Date of Signature:

For Producer Use Only

Producer ID Number: 9870	Producer Name: ISA		
Company Name:			
Street Address:			
City:	State:	Country:	Postal Code:
Telephone:	Fax:		
Signature:	E-Mail Address:		

Please complete and return with Enrollment Form to:

**Good Neighbor insurance
620 S. Winthrop St.
Gilbert, AZ 85296**

E-mail: info@gninsurance.com

Apply online at www.overseashealthinsurance.com

Additional Names of Group Members

Name (Last, First)	Birth Date mm/dd/yy	Country of Citizenship	Effective Date mm/dd/yy	# of Days	x	Daily Rate	=	Subtotal
9.					x		=	
10. 					x		=	
11.					x		=	
12.					x		=	
13.					x		=	
14.					x		=	
15.					x		=	
16					x		=	
17.					x		=	
18.					x		=	
19.					x		=	
20.					x		=	