Inbound℠ IMMIGRANT Application - 2002

OFFICIAL USE ONLY: Cert#: Processed: Eff. Date: Agent: 1009 www.otis123.com

Rates July 1, 2002 805-531-9200 or toll free **1-866-OTIS123**

All sections must be completed. Incomplete applications will be returned to the applicant without coverage.

Applicant Information

Mr. Mrs. Miss Ms. Last Name: _____ First Name: _____

U.S. Correspondence Address: Name : _____

Address: _____ City: _____ State: ___ Zip: _____
(Address must be in the United States)

Phone Number: _____ Email: _____

AD&D Beneficiary: _____ Relationship: _____

Passport & Travel Information

Passport Number: _____ Country Issuing Passport: _____

When did or will you arrive in the United States? ___ / ___ / ____ Date you would like coverage to begin: ___ / ___ / ____

Note: This program is not available to United States citizens. Your coverage must begin within twenty-four (24) months of your arrival in the United States. The minimum period of coverage is 1 month, and maximum is 12 months. If 3 or more months of premium are sent, an automatic renewal notice will be sent to the address above. Total program length available is 60 months. Coverage cannot begin until you depart from your Home Country and SRI both receives and accepts your application and correct premium.

Coverage Requested

Have you purchased insurance through SRI before? ___No ___Yes If Yes, ID Number: _____

Selected Medical Policy Maximum: ☐ Plan A: $50,000 ☐ Plan B: $100,000

Selected Per Injury/Sickness Deductible: ☐ $75 ☐ $150 (or 70 and over at $250)

If there are one or more applicants below age 70 and one ore more applicants age 70 and above, separate applications must be submitted.

Name of Persons to be Insured	**Date of Birth**	**Monthly Premium**
Applicant: _____	__ / __ / ____	_____
Spouse: _____	__ / __ / ____	_____
Child: _____	__ / __ / ____	_____
Child: _____	__ / __ / ____	_____
Child: _____	__ / __ / ____	_____
	Totals:	_____

A	x		=	B	+	$10	=	C
Total from Above		Number of months				Administrative Fee (required)		Total Payment Enclosed

Method of Payment

☐ Check ☐ Money Order ☐ MasterCard ☐ Visa ☐ Discover

Card Number: _____ Name on Card: _____

Expiration Date: _____ Daytime Phone: _____

Billing Address: _____

Signature (Required) _____

Make Check or Money Order Payable to: "SRI". Total Payment for the Full Term of coverage requested on this application 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 Credit Card Company. I declare that I agree and I agree to read and understand the terms and conditions of this product as outlined in this brochure and the program summary, including coverage is not available to any U.S. citizen. I understand that pre-existing conditions, as defined in this brochure, are not covered. I understand that this is not a general health insurance product, but a limited benefit program designed to provide basic benefits under certain circumstances.

I hereby subscribe to the AIG Life Trust and enroll in the group coverage for which I am eligible under the group contract issued by The Insurance Company of the State of Pennsylvania, a member of the American International Group, Inc. (AIG). As signatory, I declare that I am affirming all statements for all persons listed on the application (and declare that I have the authority to do so).

_____

Signature of Insured or Proxy (Required) Date

Fax Application to: 805-531-1161