LIAISON® International Application – 2005

Official Use Only: Cert # Processed Eff. Date Agent: 1009

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 5 days, the maximum is 12 months (please see Continuing Coverage Option). Coverage must be purchased in increments of no less than 5 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:	Option	Factor
	☐ $0	1.30
	☐ $100	1.10
	☐ $250	1.00
	☐ $500	.90
	☐ $1000	.80
	☐ $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 5 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(checks must be issued from a U.S. bank) 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)

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