

Application- Liaison Traveler

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

805-531-9200 or Toll Free 1-866-OTIS123

Applicant Information

Mr. Mrs. Miss Ms
Last Name: _____
First Name: _____ MI _____
Date of Birth: ___ / ___ / ___ (month/day/year)
Passport Number: _____
Issuing Country: _____

What do you consider your Home Country?

Address of Correspondence

Address: _____

City/State: _____
Postal Zip Code: _____ Country: _____
Work phone () _____ Home phone () _____
Email Address _____

For AD&D benefit...

Beneficiary _____
Relationship _____

For Couple or Family Coverage...

Names of additional persons to be insured?	Date of Birth
Spouse _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___
Child _____	___ / ___ / ___

(please attach separate sheet for additional children)

Have you purchased insurance through SRI before?

Yes No

If yes, when? From _____ to _____

Requested Effective Date of coverage:

Month: ___ Day: ___ Year: ___

*Note: Coverage cannot begin until SRI receives your application and correct premium.

Calculating Your Premium

Select Policy Period: 3-Months 6-Months 12-Months

Select Plan Type: Single (applicant only) Couple Family
(Be sure to use correct premium)

	Premium
Standard Program	\$ _____

Standard Upgrade Options (if applicable)

Increase AD&D to: \$ _____ \$ _____

Personal Liability Program (The U.S. must be your Home Country)	\$ _____
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Plus Admin Fee: \$ 10.00

Total Payment Enclosed: \$ _____

Method of Payment

Check Money Order MasterCard Visa Discover
Card# _____

Expiration Date: _____ Daytime phone: _____

Name as it appears on card _____

Signature (required) _____

Billing Address: _____

Only one Liaison Traveler program may be purchased for any given policy period. 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 credit card company. I declare that I understand the terms and conditions of this product, as outlined in this brochure. 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 American International Group, Inc. (AIG).

Signature of Insured or Proxy _____ Date (required) _____

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Fax Application to: 805-531-1161