

# PREMIUMS

# ENROLLEE INFORMATION - DIPLOMAT AMERICA Please print clearly.

DA 08/04

Rates are based on a \$ 250 deductible. This plan is for individuals while visiting the USA.

Age	Plan A \$50,000		Plan B \$100,000	
	Month	15 day	Month	15 day
18 - 29	\$63	\$41	\$81	\$48
30 - 39	\$86	\$55	\$99	\$56
40 - 49	\$124	\$78	\$150	\$84
50 - 59	\$175	\$106	\$213	\$116
60 - 64	\$200	\$123	\$275	\$151
65 - 69	\$249	\$153	\$306	\$169
70 - 79	\$331	\$181	N/A	N/A
80 +	\$544	\$314	N/A	N/A
Dep.Child	\$40	\$29	\$43	\$30
Child Alone	\$60	\$41	\$64	\$43

Age	Plan C \$250,000		Plan D \$500,000	
	Month	15 day	Month	15 day
18 - 29	\$91	\$50	\$106	\$59
30 - 39	\$111	\$60	\$150	\$83
40 - 49	\$169	\$93	\$214	\$118
50 - 59	\$239	\$131	\$300	\$165
60 - 64	\$310	\$170	N/A	N/A
65 - 69	\$344	\$189	N/A	N/A
Dep.Child	\$48	\$31	\$58	\$33
Child Alone	\$71	\$44	\$69	\$45

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Home Country Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Country \_\_\_\_\_  
 Passport Number \_\_\_\_\_ Issuing Country \_\_\_\_\_

**For Accidental Death Benefit:**

Beneficiary \_\_\_\_\_  
 Relationship to enrollee \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_

**Send Policy to:**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone \_\_\_\_\_

**Calculating Your Premium**

**Policy Maximum:** (Circle one)  
 Plan A: \$50,000  
 Plan B: \$100,000  
 Plan C: \$250,000  
 Plan D: \$500,000

**Deductible Options and Factors:** (Circle one)  
 \$100 x 1.10      \$1000 x .80  
 \$250 x 1.00      \$2500 x .70  
 \$500 x .90

**Optional Riders and Factors:**  
 (Circle all that apply)  
 Hazardous Activity x 1.25  
 Athletic x 1.20

Requested Effective Date \_\_\_\_\_ Termination Date \_\_\_\_\_

**Names of Persons to be Insured**

Enrollee \_\_\_\_\_  
 Spouse \_\_\_\_\_  
 Child \_\_\_\_\_  
 Child \_\_\_\_\_

**Gender**

M or F  
 M or F  
 M or F  
 M or F

**Date of Birth**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Monthly Premium**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**15 Day Premium**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please attach additional sheet for more children

**Total Month (A)**

**Total 15 day (B)**

(A) _____ x _____ = (C) _____	+ (B) _____ = (D) _____	sub-total
<small>month premium</small>	<small>number of months</small>	<small>15 day premium</small>
(D) _____ x _____ = (E) _____	+ \$10.00 = \$ _____	<b>TOTAL PREMIUM</b>
<small>sub-total</small>	<small>deductible factor</small>	<small>Administration Fee</small>

*Refund of premium, less a \$25 processing fee, will be considered only if written request is received by Global Underwriters prior to the effective date of coverage. After that date, the premium is considered fully earned and non-refundable. Partial refunds are not available. Coverage cannot begin until Global Underwriters receives your complete enrollment form and correct premium.*

**Payment Method** Check/Money Order (Payable to Global Underwriters) MasterCard/Visa/Discover

Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Expiration date \_\_\_\_ / \_\_\_\_  
 Cardholder Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Cardholder City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I have read and fully understand the exclusions list on this brochure. Check or money order must be made payable to Global Underwriters Inc.. All premium payments must be made in U.S. dollars at the time enrollment in coverage is made. If paying by credit card, I authorize Global Underwriters Agency Inc. to bill my Visa/MasterCard/Discover account for the total premium. Coverage purchased by credit card is subject to validation and acceptance by the credit card company. I hereby subscribe to the Diplomat America plan and enroll in the coverage for which I am eligible under the policy issued by The Insurance Company of the State of Pennsylvania, a member company of American International Group, Inc. (AIG).

Signature of Insured or Proxy \_\_\_\_\_

Date \_\_\_\_\_

Agent Name/# \_\_\_\_\_

GA Name/# \_\_\_\_\_

Return completed enrollment form and total premium