# Inbound Immigrant application 2009

[pull-out application form]

effective april 1, 2009

(please print or type using black ink) John K Arnold Agent 4449

**Official Use Only:**

Cert#: Processed: Eff. Date: Agent: 4449

## applicant information

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Last Name: _____

First Name: _____

**u.s. correspondence address:** *(Address must be in the United States)*

Name : _____

Address: _____

City / State / Zip: _____

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?

*(MM/DD/YYYY)* _____ / _____ / _____

Date you would like coverage to begin:

*(MM/DD/YYYY)* _____ / _____ / _____

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 5 days, maximum is 12 months. If 3 or more months of premium is 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 Seven Corners both receives and accepts your application and correct premium.

## calculating your plan cost

*(Please complete entire section.)*

| Name of Person(s) to be Insured: | Date of Birth MM/DD/YY | Monthly Rate | Daily Rate |
|---|---|---|---|
| Applicant: _____ | __/__/__ | | |
| Spouse: _____ | __/__/__ | | |
| Child: _____ | __/__/__ | | |
| Child: _____ | __/__/__ | | |
| Child: _____ | __/__/__ | | |
| | **Total:** | **$** | **$** |

| | | |
|---|---|---|
| Multiply Monthly Rate Total by number of months: | x | |
| Monthly Total [A]: | | $ |
| Multiply Daily Rate Total by number of days: | x | |
| Daily Total [B]: | | $ |
| Administrative Fee ($5.00 - Required): | + | $5.00 |
| **Total Payment Enclosed:** | | **$** |

## coverage specifics

**Have you purchased insurance through Seven Corners 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 :

❑ $125 ❑ $250

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

**Do You Want a Paper ID Card Mailed to You?**

❑No ❑Yes

## method of payment

❑ Check ❑ Money Order ❑ MasterCard ❑ Visa

❑ Discover ❑ American Express

Card Number: _____ CVV_____

Expiration Date: _____ Daytime Phone: ( ) _____

Name on Card: _____

Billing Address: _____

Signature *(Required)* _____

Make Check or Money Order Payable to: "Seven Corners". 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 to and have 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 AIU Holdings, 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 AIU Holdings. 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



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