Insured's Name / Nationality	Date of Birth	Passport Number/SSN	Monthly Rate	Daily Rate*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
SUBTOTAL:			A	B

Calculating Your Premium ***(Check one plan and one option)*:**

Select the coverage plan and plan option:

❑ **Patriot America℠ for non-US citizens**

Option 1__ Option 2__ Option 3__ Option 4__

❑ **Patriot International℠ for US citizens**

Option 5__ Option 6__ Option 7__ Option 8__ Option 9__

Names of individuals to be covered under this policy (attach additional sheets if necessary). *Daily rate available only if 15 day minimum period of coverage is satisfied.

Circle One	
Deductible	**Rate Factor**
US$100	1.1
US$250	1.0
US$500	.90
US$1000	.80
US$2500	.70
Sports Factor	1.20

_____X_____=_____ **AND/OR** _____X_____=_____

A (total monthly rate from table above) Number of months **C** **B** (total daily rate from table above) Number of days **D**

_____+_____=_____X_____X_____+_____=$_____

C (from line above) **D** (from line above) Deductible rate factor (See box at right) Sports Rider Factor (Enter 1.2 if applicable) US$20.00 optional express mail, fax confirmation or special correspondence *(circle one if applicable)* **Total Premium**

To Pay in Monthly Installments

_____÷_____=_____+ $10.00 =$_____

Total Premium Number of months Billing fee Periodic payment

↑

Minimum initial payment required

Selling Agent Use Only

Agency# Zain Jeewanjee Insurance Agency GA# 16509

Name Zainuddean Jeewanjee

Address 6155 Almaden Expy. Suite 310

City San Jose Phone: (408) 323 9980

State CA Zip Code 95120

0401 Updated 4/01

TEAR HERE TEAR HERE TEAR HERE

To Enroll

1. Complete entire Enrollment Form.
2. Please make check or money order payable to IMG and enclose in envelope with signed Enrollment Form
3. Mail or fax to:

   G1G Insurance Services
   6155 Almaden Expy. Suite 310
   San Jose, CA 95120
   Fax: (408) 997 7890

Please Print:

Sponsoring Organization_____

_____

Address_____

_____

City/State/Zip_____

Phone_____

Fax_____

Contact Name_____

Requested Effective Date_____

Date of Departure_____

Requested Expiration Date_____

Purpose of Trip_____

Destinations_____

_____

Beneficiaries

In the event of the insured's death, the beneficiaries will be as follows:

1) Spouse - Primary
2) Children - Contingent
3) Estate of the insured - Contingent

Payment Method ❑ Check ❑ Money Order

❑ Mastercard ❑ Visa ❑ American Express

Card#_____Expiration date_____

Name on Card_____

Signature_____

Your Daytime Phone_____

Your Billing Address_____

_____

_____

Plan Agreement

The Sponsor agrees to pay premium hereunder to the Company on or before the due date. If the premium due under this Agreement is to be paid in installments, a grace period of 10 days will be allowed for the Company's receipt of payment of each premium except the initial installment. If any premium is unpaid at the end of a grace period, the insurance hereunder shall be terminated effective the due date of the premium, whereupon the Company's liability shall cease with respect to all claims incurred thereafter. All premium payments must be made in U.S. dollars. If paying by credit card, the Sponsor authorizes IMG to bill the credit card account for the total charges as specified herein. Coverage purchased by credit card is subject to validation and acceptance by credit card company.

The Sponsor has read this brochure and understands that the coverage provided hereunder is not a general health insurance policy. It is intended for the use of the Group members in the event of a sudden and unexpected illness or injury arising when a member is eligible for coverage under this insurance. ***This policy does not provide benefits for illness, conditions, or injuries which existed during the five years prior to the effective date of this insurance, whether known or unknown.*** *The Sponsor is not aware of any existing medical conditions for any of the Group members. To the best knowledge of Sponsor, all members of the Group are in good health and do not have any medical conditions for which they intend to claim hereunder. The undersigned is a duly authorized representative of the Sponsor and has the authority to purchase this insurance on behalf of the members listed. The Sponsor hereby subscribes to the Group Health, Accidental and Travel Insurance Trust in Indiana and enrolls in Patriot Group Travel Medical Insurance℠ under contract by Sirius International Insurance Corporation (publ). By acceptance of coverage and/or benefits, a Group member ratifies the authority of the Sponsor to bind the member hereunder. Further, all members agree to exclusion of coverage for pre-existing conditions as defined herein. The Sponsor understands that coverage under Patriot Group Travel Medical Insurance℠ is NOT RENEWABLE. Any successive enrollments in Patriot Group Travel Medical Insurance℠ are not renewals.*

Signature_____

Date_____ Phone _____

Address _____

_____

Please complete application on other side.