

**Application for SafeTrip – Oregon Residents**

Underwritten By: ACE American Insurance Company – Philadelphia, PA 19106

**Mail application to:**

MEDEX Insurance Services, Inc.  
P.O. Box 19056  
Baltimore, MD 21284  
Phone: 800-732-5309  
Fax: 410-308-7905  
8:00 A.M. - 5:00 P.M. ET, Monday - Friday

Application is hereby made for SafeTrip based on the following statements and representations:

Applicant 1 Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Ms.  Mr. (month/day/year)

Applicant 2 Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Ms.  Mr. (month/day/year)

Applicant 3 Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Ms.  Mr. (month/day/year)

Applicant 4 Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Ms.  Mr. (month/day/year)

Permanent Address:  
Street: \_\_\_\_\_  
State/Province: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Passport #: \_\_\_\_\_ Country of Issue: \_\_\_\_\_

Country(ies) of Destination: \_\_\_\_\_  
Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
Total Number of days of  
coverage requested: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Primary Health Insurance Company: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Policy: \_\_\_\_\_

**Premium Rates**

**1. Calculate Cost of Coverage:**

**I. Per Trip Enrollment**

7 day minimum, 90 day maximum per trip

$$\$3.50^* \times \frac{\text{_____}}{\text{\# of days}} = \$ \text{_____} \times \frac{\text{_____}}{\text{\# of persons}} = \$ \text{_____}$$

**\* \$5.25 for ages 71-80**

**II A. Annual Frequent Traveler**

No one trip can be more than 90 consecutive days

$$\$225.00^* \times \frac{\text{_____}}{\text{\# of persons}} = \$ \text{_____}$$

**\* \$280.00 for ages 71-80**

**II B. Annual Expatriate**

For travel greater than 90 consecutive days or greater than 180 days in a 12 month period

$$\$350^* \times \frac{\text{_____}}{\text{\# of persons}} = \$ \text{_____}$$

**\* \$425.00 for ages 71-80**

Such Premiums are due and payable in the following manner: The Applicant agrees to pay, in advance, the required Premium for these coverages.

Coverage is issued according to plan specifications and rates in effect at the time of enrollment.

**2. Payment Method**

- Check       Money Order  
 American Express       Master Card       Visa

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(month/ year)

Billing Address:

Street: \_\_\_\_\_

State/Province: \_\_\_\_\_ Postal/Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Name as it appears on card: \_\_\_\_\_ Signature: \_\_\_\_\_

If paying by credit card, I hereby authorize ACE American Insurance Company or its authorized agents to deduct the total premium due from my credit card.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

**IMPORTANT NOTICE: ANY PERSON WITH THE INTENT TO KNOWINGLY DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO THAT IS RELATED TO THE ACCEPTANCE OF THE RISK BY THE INSURER, MAY BE GUILTY OF INSURANCE FRAUD AND MAY BE SUBJECT TO PROSECUTION.**

I certify that I have read the complete plan description, and understand the terms and conditions of coverage that apply to me including any limitations or exclusions that may apply to my coverage. Further, I understand there is no coverage for loss due to pre-existing conditions, unless this insurance is purchased within the required time period to waive the Pre-existing Medical Condition Exclusion.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(month/day/year)