

# PREMIUMS

Rates are based on a \$250 deductible and policy maximum chosen. This plan has a three month minimum.

## Plan A

Age	Persons Traveling In the USA \$500,000	Persons Traveling Outside USA \$500,000
Up to 29	\$104	\$72
30 - 39	\$139	\$87
40 - 49	\$189	\$94
50 - 59	\$262	\$138
60 - 64	\$437	\$228
65 - 69	\$485	\$253
70 - 79*	\$503	\$341
80 +**	\$578	\$392
Dep.Child	\$49	\$39

## Plan B

Age	Persons Traveling In the USA \$1,000,000	Persons Traveling Outside USA \$1,000,000
Up to 29	\$125	\$86
30 - 39	\$166	\$105
40 - 49	\$225	\$112
50 - 59	\$313	\$165
60 - 64	\$498	\$261
65 - 69	\$551	\$287
Dep.Child	\$59	\$46

\* Benefits are reduced to \$ 100,000 at ages 70-79

\*\* Benefits are reduced to \$50,000 at age 80

Return completed enrollment form and total premium payment to Administrator:

Global Underwriters Agency Inc.

3195 Linwood Rd. Suite 201 Cincinnati, OH 45208

Credit card enrollment form can be faxed to:

800-942-7816 or 513-533-3775

Apply online at: [www.globalunderwriters.com](http://www.globalunderwriters.com)

# ENROLLEE INFORMATION - DIPLOMAT LT (Three Month Minimum) Please print clearly. DLT 08/04en

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

### For Accidental Death Benefit:

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

### Send Policy to:

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

### Calculating Your Premium

#### Policy Maximum: (Circle one)

Inside USA Coverage    Outside USA Coverage  
 Plan A: \$500,000    Plan A: \$500,000  
 Plan B: \$1,000,000    Plan B: \$1,000,000

#### 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  
 Home Country x 1.10

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

Termination Date \_\_\_\_\_

### Names of Persons to be Insured

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

Gender	Date of Birth	Monthly Premium
M or F	___/___/___	_____
M or F	___/___/___	_____
M or F	___/___/___	_____
M or F	___/___/___	_____

Please attach additional sheet for more children

\_\_\_\_\_

**Total Month (A)**

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

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 LT 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/# \_\_\_\_\_