# ATLAS GROUP TRAVEL APPLICATION
## HCC Medical Insurance Services
## Lloyd's Coverholder

Print all Names as you would like them to appear on your Identification Cards.
Please print clearly and provide complete information.

| Name of Sponsoring Organization: | Contact Name: | |
|---|---|---|
| COMPLETE Mailing Address for all correspondence: | | |
| Telephone #: | Fax #: | E-mail Address: |
| Destination: | Purpose of Trip: | |

| Names of **all** individuals to be covered. | **Deductible: $** | | | **Maximum Benefit: $** | | | | |
|---|---|---|---|---|---|---|---|---|
| **Name (Last, First)** | **Birth Date (mm/dd/yy)** | **Gender** | **Citizenship** | **Departure Date (mm/dd/yy)** | **Return Date (mm/dd/yy)** | **# of Days** | **Daily Rate** | **Individual Subtotal** |
| **1.** | / / | | | / / | / / | | | |
| **2.** | / / | | | / / | / / | | | |
| **3.** | / / | | | / / | / / | | | |
| **4.** | / / | | | / / | / / | | | |
| **5.** | / / | | | / / | / / | | | |

**Group Subtotal – Total from above and from additional census (if any) (A):** ________

**Enter Deductible Factor from Deductible Factor Table (B):** ________

**Enter Factor for Sports Rider, if Selected (1.2). Otherwise Enter 1.0 (C):** ________

**Total Amount Due (A x B x C):** ________

**Florida Surplus Lines question**
(applies to Atlas Group America only):

Will your group be traveling to Florida to work? ☐ Yes ☐ No

| Form of Payment: ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover Card ☐ Check/Money Order | Name as it appears on card: |
|---|---|
| Credit Card #: Expiration Date (mm/yy): | Complete Billing Address (include daytime phone #): |
| Signature: | |
| **Payment by Credit Card:** By signing above, the cardholder authorizes HCC Medical Insurance Services to debit his or her Discover, VISA, MasterCard or American Express account for the amount specified above. Please submit this completed Application by mail or by fax to your Agent or to HCCMIS.<br>HCC Medical Insurance Services<br>251 North Illinois Street, Suite 600<br>Indianapolis, IN 46204 | Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please send your Check or Money Order along with this Application via mail or courier to:<br>Bank of America Lockbox Services<br>c/o Lockbox # 15748<br>540 W. Madison 4th Floor<br>Chicago, IL 60661 |

Total payment for the initial term of coverage requested must be entirely paid in U.S. dollars at time of application or prior to the Effective Date of Coverage. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

The Sponsoring Organization (Sponsor), on behalf of and as authorized agent and proxy for each of the group participants listed on the Application, hereby applies for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to members by Lloyd's. The Sponsor and all group participants understand that the insurance applied for is not a general health insurance policy, but is intended for use by members in the event of a sudden and unexpected event while traveling outside their Home Country(ies). The Sponsor and all group participants understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. The Sponsor and all group participants understand that coverage under this insurance is not renewable and successive periods of insurance will require re-satisfaction of the Deductible, Coinsurance, Pre-existing Condition provision, and all other conditions of the insurance following acceptance of a new Application. The Sponsor and all group participants understand that the information contained herein is a summary of the Master Policy and that they may obtain a complete copy of the Master Policy upon request to HCC Medical Insurance Services. The Sponsor and all group participants understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. The Sponsor and all group participants understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. The Sponsor and all group participants understand and agree that the insurance agent/broker, if any, assisting with this Application is their representative. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. If signed by a representative of the Sponsor, the undersigned warrants his/her capacity to so act. If signed as Sponsor, the undersigned warrants his/her authority to so act. By acceptance of coverage and/or submission of any claim for benefits, the each group participant ratifies the authority of the signer to so act and bind the group participant.

| Signature of Sponsor: | Date of Signature: |
|---|---|

**For more information or for assistance completing this application, please contact:** **Producer Number:** 9800

HCC Medical Insurance Services / 251 North Illinois Street, Suite 600 / Indianapolis, IN 46204
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