ATLAS PROFESSIONAL APPLICATION
HCC Medical Insurance Services
Lloyd's Coverholder

Please print clearly and provide complete information.

Please select your area of coverage:	☐ **Excluding the US**	☐ **Including the US** *Available to non-US citizens and residents only

Names of **all** individuals to be covered. Print all Names as you would like them to appear on your Identification Cards.

Name (Last, First)	Birth Date (mm/dd/yy)	Gender	Citizenship	Annual Premium
Insured:	/ /			
Spouse:	/ /			
Child 1:	/ /			
Child 2:	/ /			
Child 3:	/ /			

Subtotal (A): _____

Enter Additional Premium for Optional Sports Rider (B):
(If selected, must purchase for all individuals) _____

Enter Additional Premium for Optional Atlas Terrorism Rider (C):
(If selected, must purchase for all individuals) _____

Total Amount Due (A + B + C): _____

Requested Effective Date (mm/dd/yyyy):	Send Certificate of Insurance to (Name and Mailing Address):
Name of Beneficiary:	
Form of Payment: ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover Card ☐ Check/Money Order	
Name as it appears on card:	E-mail Address:
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. HCC Medical Insurance Services 251 North Illinois Street, Suite 600 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: Bank of America Lockbox Services c/o Lockbox # 15748 540 W. Madison 4th Floor 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.	

I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda, and for the insurance provided to members by Lloyd's. I understand that only losses resulting from Accidents which occur outside my Home Country, while in a covered Country as listed on my Application are covered. I understand that all premiums are non-refundable after departure from Home Country. I understand this insurance is not renewable. I understand that the information contained herein is a summary of benefits, limitations and exclusions and that I may obtain a complete copy of the Master Policy by contacting HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I 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. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. 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 Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

Signature of Applicant:	Date of Signature:
Signature of Spouse:	Date of Signature:

For more information or for assistance completing this application, please contact:
HCC Medical Insurance Services / 251 North Illinois Street, Suite 600 / Indianapolis, IN 46204
Phone: 800-605-2282 / 317-262-2132 / Fax: 317-262-2140 / E-mail: insurance@hccmis.com

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