Medical Insurance Services Group
251 North Illinois Street, Suite 600, Indianapolis, IN, 46204 USA
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Atlas MultiTrip ™

Atlas MultiTrip America – For Non-U.S. Citizens Traveling to the U.S.		
Maximum Trip Duration	30 Days per Trip	45 Days per Trip
Participant - Annual Premium	$257.00	$315.00
Spouse and up to two children*	$131.00	$162.00
Each additional child*	$51.00	$63.00

Atlas MultiTrip International – For Travel Outside of the U.S.		
Maximum Trip Duration	30 Days per Trip	45 Days per Trip
Participant - Annual Premium	$188.00	$230.00
Spouse and up to two children*	$94.00	$115.00
Each additional child*	$38.00	$46.00

Rates are shown in US dollars and are effective 04/01/17. Rates are subject to change. Surplus Lines taxes and fees will be charged when applicable.

Eligibility for Atlas MultiTrip policy coverage requires that each applicant's age be between 14 days and up to 75 years of age.

*Children under 19 years of age

Premiums are fully earned on the Certificate Effective Date and are nonrefundable thereafter.

Tokio Marine HCC Medical Insurance Services Group (MIS Group) is a member of the Tokio Marine HCC group of companies. Tokio Marine HCC - MIS Group has authority to enter into contracts of insurance on behalf of the Lloyd's underwriting members of Lloyd's Syndicate 4141, which is managed by HCC Underwriting Agency LTD.

ATLAS MULTITRIP™ APPLICATION
Tokio Marine HCC - Medical Insurance Services Group
Lloyd's Coverholder
Please print clearly and provide complete information.

1. **Please select your area of coverage:** ☐ **Excluding the U.S.** ☐ **Including the U.S.** (Available to Non-US citizens and residents only)

2. **Destination Country:** _____ and **Home Country:** _____

3. **Start Coverage Date (mm/dd/yyyy):** ___/___/_____

4. **I understand this 364-day policy provides coverage for trips of short durations as selected below.** ☐ **Yes**

5. **Select Trip Duration** (See attached Rate Sheet for the applicable trip duration rates): ☐ **30-days or less** ☐ **45-days or less**

6. **Do you maintain medical insurance coverage in your Home Country?** ☐ **No** ☐ **Yes**

7. **Beneficiary:** _____

Please print information for **all** individuals to be covered. In lieu of table below, this applicant list may be submitted by attaching a spreadsheet.

	Name (Last, First)	Birthdate (mm/dd/yyyy)	Gender	Citizenship	Annual Premium*
Insured:		/ /			
Spouse:		/ /			
Child 1:		/ /			
Child 2:		/ /			
Child 3:		/ /			

***Florida Surplus Lines (Tax)**: Is group traveling to FL to work? If yes, multiply "individual" rates for all purchases/Buy-Ups** by 1.051

Subtotal (A): _____

****Purchase Buy-Ups?** ☐ Accidental Death & Dismemberment ☐ Crisis Response ☐ Personal Liability **Subtotal (B):** _____

TOTAL AMOUNT DUE – Total from above Lines A and B and from additional census (if any): _____

Form of Payment: ☐ Credit Card ☐ Check/Money Order		Name on card & Mailing Address:	Billing Address & daytime phone:
Email Address:			
Credit Card #:	Expiration Date (mm/yy):		
Signature:			

Payment by Credit Card: By signing above, the cardholder authorizes Tokio Marine HCC - Medical Insurance Services Group 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 Tokio Marine HCC - MIS Group.

Tokio Marine HCC - Medical Insurance Services Group
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:

HCC Medical Insurance Services
15748 Collection Center Dr.
Chicago, IL 60693-0157

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 the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand that my insurance terminates upon my return to my Home Country unless I qualify for a Benefit Period or Home Country Coverage. I understand this insurance contains a Pre-existing Condition exclusion and other restrictions and exclusions. I understand that, prior to my current coverage expiration date, I can visit the Tokio Marine HCC – MIS Group Client Zone for transaction instructions regarding policy extensions and/or renewal eligibility. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to Tokio Marine HCC - Medical Insurance Services Group. 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 Tokio Marine HCC - Medical Insurance Services Group. 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: Producer Number: _____